Religiöse Diversität im portugiesischen Krankenhaussektor
Religious Diversity in the Portuguese hospital sector

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Abstract:
Between 2001 and 2009, religious assistance in Portuguese public hospitals moved from a traditional chaplaincy model, where Roman Catholic chaplains stood as the only official religious representatives within hospital premises, to a legally enforced pluralistic model where religious diversity is both a challenge and a resource to religious actors. As a comparative case study of three high-end, public university hospitals in Portugal, this dissertation shows that religious assistance provision became contentious as the dominance exerted by the Roman Catholic Church in the specific case of religious assistance within hospitals was challenged by legal changes which are not fully implemented.
Legal change towards a transition between traditional chaplaincies and Spiritual and Religious Assistance Services produced divergent results across the three cases studied in this dissertation, as the set of religious representatives within each hospital negotiated through specific local orders in order to achieve strategic goals. This divergent pattern is the most important research puzzle in this study. In this dissertation, it is proposed that religious assistance in public hospitals operates along four dimensions: the level of organizational integration of religious assistance services, their strategic orientation, their institutional underpinnings and their cognitive orientations. These dimensions determine, to a large extent, the patterns of strategic action by religious representatives within hospitals. This dissertation finds that each of the three cases studied, while integrated in a single legal and operational framework, diverge in their level of organizational integration and this is the core cause of all remaining differences across other dimensions.

Keywords: Religion, Hospitals, Hospital Chaplaincy, Portugal, Religious Assistance

Zusammenfassung:
Zwischen 2001 und 2009, veränderte sich die religiöse Betreuung in portugiesischen öffentlichen Krankenhäusern von einem traditionellen Modell der Betreuung durch Kapläne, in dem Römische Katholische Kapläne die einzigen offiziellen religiösen Vertreter auf dem Krankenhausgelände waren, auf ein gesetzlich erzwungenes pluralistisches Modell, wo die religiöse Vielfalt sowohl eine Herausforderung als auch eine Ressource für religiöse Akteure bedeutet.
Als Vergleichsfallstudie von drei High-End, öffentlichen Universitäts Krankenhäusern in Portugal zeigt diese Dissertation, dass die Bestimmung von religiöser Unterstützung strittig wurde, sobald die durch die Römische Katholische Kirche ausgeübte Dominanz in dem

speziellen Fall des religiösen Beistands in Krankenhäusern durch Gesetzesänderungen in Frage gestellt wurde, die noch nicht vollständig umgesetzt sind.
Rechtsänderungen in Richtung eines Übergangs zwischen traditionellen Kaplansämtern und Leistung Geistiger und Religiöser Unterstützung produzierten unterschiedliche Ergebnisse in den drei untersuchten Fällen in dieser Dissertation. Jede Gruppe religiöser Vertreter innerhalb jedes Krankenhaus hat gezielt lokale Aufträge ausgehandelt, um Ihre strategischen Ziele zu erreichen. Dieses divergierende Muster ist das wichtigste Forschungsrätsel in dieser Studie.
In der vorliegenden Arbeit wird vorgeschlagen, dass die religiöse Betreuung in öffentlichen Krankenhäusern entlang von vier Dimensionen betrieben wird: das Niveau der organisatorische Integration der religiösen Hilfeleistungen, deren strategischen Ausrichtung, deren institutionelle Untermauerung und deren Kognitiven Orientierungen. Diese Dimensionen bestimmen zu einem großen Teil, die Muster des strategischen Handelns der religiösen Vertreter in Krankenhäusern.
Die vorliegende Arbeit stellt fest, dass jeder der drei untersuchten Fälle, obwohl integriert in einem einzigen rechtlichen und operationellen Rahmen, in seinem Niveau der organisatorischen Integration divergiert und das dass die Kernursache aller folgenden Unterschiede zwischen den anderen Dimensionen ist.

Schlagwörter: Religion, Krankenhäuser, Krankenhausseelsorge, Portugal, Religiöse Hilfe

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CHAPTER 1: Introduction

This dissertation is a study on the organization of religious assistance in Portuguese public hospitals. The core research problem is framed by three research questions of decreasing importance. First, why do healthcare public institutions facing similar regulatory constraints show different patterns of religious assistance? Second, how do religious representatives act upon perceived constraints in terms of their lived religious experiences? Third, how does instability transfer from one strategic field to another (in this case, from the religious field to the healthcare policy field)? These questions drive a comparative-historical analysis of religious assistance services and regimes in three large public hospitals in Portugal. The working hypothesis presented in this study is that State-religion relations regimes are not as relevant to organizational practice, at least in the healthcare sector, as the religious assistance regimes that arise out of sector-specific processes and structures. Hospitals do not deal with religious diversity as required by the overarching legal and political framework in Portugal; instead, their organizational matrix derives from the interplay of actors and path-dependent processes that are constrained but not determined by State-religion relations.

1.1 Chaplaincy and religious assistance

Religious assistance services are institutional and organizational arrangements which seek to provide patients with non-physical care framed within religious tenets. These services may be provided by any religious representative accredited by her religious tradition. The difference between chaplaincy and religious assistance lies at the core of this study. The first denotes a Christian-centric view of religious care where a priest engages in sacramental care for those in need of solace. Chaplaincy is a core function in various Christian traditions which emphasize a "ministry of presence" (Sullivan 2014). It is also the object of theological arguments. Healthcare chaplaincy, in particular, is seen as a fundamental duty for ordained priests in Christian traditions. The second denotes a pluralistic view of religion which asserts diversity as the core issue for religious caregivers. In this study, "religious assistance" is used interchangeably with "spiritual and religious assistance" because, in the case of Portuguese public hospitals, there is no empirical difference between the two. Spiritual care is either non-existent or seen as religious care without its sacramental components.

Between 2001 and 2009, healthcare policy moved from the acceptance of a single, rigid chaplaincy regime to the implementation a flexible religious assistance regime which sought to change the *statu quo*. While the initial goal was to displace religion from hospitals in its entirety, the end result sought to promote a power rebalance: whereas Catholic chaplains were seen as the only officially-accredited religious representatives, they were, after 2009, repositioned as members of a more inclusive regime. Official accreditation was legally extended to other religious traditions. This top-down transition was legally mandated by a regulatory amendment to the 2001 Law on Religious Freedom and the 2004 Concordat between the Portuguese State and the Vatican. It was thus expected to level the playing field at the hospital level. Implicitly, these changes challenged the dominant settlement in the Portuguese religious field and the state of play in Portuguese public hospitals. In the former, the Catholic Church was the dominant player. In the latter, Catholic chapels were (and are) the single physical space in most Portuguese hospitals. Catholic chaplains sat (and sit) in most hospital ethics committees and are seen, sometimes grudgingly, as relevant members of the care community. According to the narrative offered by State-religion relations in Portugal, transitioning from Catholic dominance to liberal diversity necessitated a regime change that tackled all public institutions.

This analysis employs insights from the emerging strategic action field approach and organizational institutionalism to suggest that patterns of religious assistance are the result of individuals acting upon power-distributional asymmetries. Catholic chaplains in Portuguese public hospitals are both powerful and powerless; they are constantly traversing boundaries and switching discourses in order to make religion legitimate in a secular environment while maintaining a gatekeeping role in relation to religious traditions which seek entrance into hospitals. Other religious representatives are not powerful in any meaningful sense. They operate at the behest of Catholic chaplains, which exert authority as street-level bureaucrats (Lipsky 2010), and this asymmetrical relationship questions the religious pluralism narrative sustained by the Portuguese State, the Catholic Church and select religious traditions. The provision of spiritual and religious assistance is a surprisingly effective testing ground for arguments on interest group power and legitimacy in the healthcare policy and religious fields. Chaplains are forced to seek a fragile balance between their sacramental roles and their legitimacy as caregivers; furthermore, the Catholic Church and the State demand their service as gatekeepers to other religious traditions. These relationships are contextualized by the strength of Catholic Church influence over policy definition and implementation. This study

suggests that the transition from chaplaincy services and regimes to their spiritual and religious assistance counterparts remains incomplete because the politics of that transition has not transformed the fundamental centrality of the Catholic Church in the provision of healthcare and what is still perceived to be the mission of religion in healthcare settings.

This study contends that, as far as religion in healthcare is concerned, institutional arrangements such as State-religion relations are less important that organizational power distribution; high-level regulatory constraints are only as important as religious representatives working in or through hospitals interpret them to be. Where Catholic chaplains benefit from high levels of organizational legitimacy – as a consequence of their individual social and cultural capital –, the likelihood of more entrenched and legitimate religious assistance increases. Conversely, where there is no leadership, religious assistance is seen as less legitimate and operates at the margins of the hospital. Lived religion, as the actual experience and practice of religion in public organization, is at least as important as the specific type of State-religion relationship in a given national case. In each of the three hospitals detailed in this study, specific configurations of religious assistance emerged for organization-specific reasons. There is a degree of convergence caused by a single regulatory regime which forced organizations into a single structure and public hospitals are underpinned by similar organizational secularities. But legislation was and is not easily internalized as policy and, most important, everyday practice.

1.2 Public hospitals

Portuguese public hospitals have developed from Catholic Church-governed institutions, where chaplaincies stood at the core of institutional practice. Healthcare in Portugal has never strayed far from the religious field in a very concrete sense. Healthcare is seen as central by most religious traditions; indeed, religion asserts numerous propositions with regard to the human condition that are historically intertwined with healthcare. This is an additional reason why the study of religion in healthcare is relevant. The historical development of State-religion relations in the country is driven by the centrality of the Catholic Church. To a large extent, the legitimacy of religious traditions in the Portuguese religious field is first ascribed by the Catholic Church and its representatives and then seconded by the State. Religious assistance in Portuguese public hospitals is a striking representation of this process. As a form of care, it only transitioned from the Christian-centric “chaplaincy” designation to its “spiritual and

religious assistance" counterpart in 2009, after severe political turmoil between 2001 and 2009. Events in these years show how religious field instability fed into healthcare, forcing chaplains to change their perceived position in hospitals and seek legitimacy. Indeed, the political process leading to a 2009 regulation was fraught with tension within the healthcare policy field and the religious field itself. Both quickly resettled into consensus, but variation, as suggested above, remains very high.

There is no non-Catholic led religious assistance service in any public hospital; all are headed by a Catholic chaplain. It would then make sense to ask which hospitals would be eligible for further research into the development of spiritual and religious assistance as a replacement for chaplaincy. Case selection procedures led to three high-end public hospitals. These hospitals share more similarities amongst one another than any other healthcare facilities in Portugal. Lower-level hospitals do not lodge most significant medical specializations, do not have large budgets and do not lodge medical colleges. Lower-level facilities do not support very large populations. If it is at all possible to maintain a level of control over case variation, these hospitals are the best choice for comparative work. To what extent did chaplaincy change into spiritual and religious assistance in each of these hospitals? It is expected that there should be at least a significant level of convergence. But there is not.
Their spiritual and religious assistance services are very different and can be placed along an accommodation scale.

In each case, religious representatives negotiate through boundaries and seek legitimacy in a context which is, at worst, hostile and, at best, nurturing at a distance. Where it is hostile, as shown in one of the cases, religious assistance suffers from legitimacy issues that paradoxically reinforce the maintenance of a chaplaincy model which is seen as anachronistic by chaplains. The chaplaincy model does not favor the accommodation of religious traditions; as the single dominant tradition, Catholicism, is locked in a struggle for its own survival, it tends to seek legitimacy outside the hospital and represents itself as a hospital parish of sorts. The hospital is hostile because its power structures feed into a specific form of organizational secularity. It excludes religion and reinforces biomedical discourse as the only eligible pillar for a techno-scientific organization. Where the context is neither hostile nor nurturing, the chaplaincy model gives way to a religious assistance service which opens the opportunity structure for skilled chaplains to engage with religious traditions if they determine this to be a desirable solution. One case in this study fits this description. The other end of the continuum suggested above is

a context where religious assistance is nurtured, but always to a point and never fully embraced as an entirely legitimate component of hospital operation processes. The chaplaincy model has given way to a fully operational spiritual and religious assistance model. While the two configurations mentioned above struggle to fit in the hospital organizational structure, in this case the religious assistance service struggles to gain full legitimacy and thus takes steps to remake itself as an accredited sector in the hospital. Its claim to legitimacy hinges on its ability to comply with the isomorphic pressure of the hospital itself. It is no longer a healthcare chaplaincy; it seeks to transition into an accredited caregiving service, able to measure its capacity, performance and impact. This study is thus a stepping stone in the formulation of typologies and testable propositions regarding religious assistance services.

When the head chaplain of a Portuguese public hospital is asked to tell a story, he will likely begin by shattering stereotypes. He will talk about support, presence, silence and "just standing there". There will be little overt talk of Christian theology and lots of references to holistic understandings of what it is to be human. "Wholly human", most of them say. Portuguese hospitals, in their view, are not pleasant. Not because they do not attend to the needs of religious traditions, but because they fail to see their patients outside the narrow scope of biomedical ideas: patients go to hospitals in order to seek treatment; they carry illnesses that should be extracted efficiently; physicians should rely on technology-heavy medicine and disregard concerns for the emotional and spiritual wellbeing of patients (Conrad 1992, 2008). They are, according to several participants in this study, "screen doctors": physicians who, upon the initial consult, keep a strict medical gaze on the patient, type technical remarks in digital folders and ask pointed questions about the physical state of the person standing in front of them. This stereotype guides the contrasting light in which religious representatives seek to fashion their role in contemporary Portuguese public hospitals. These representatives stand in contrast to the medical gaze. But their gaze is only religious insofar as they enter hospital boundaries because they are seen as religious.

At the outset, I attempted to build a framework that encompassed three of those institutions: the public education system, the prison system and the health system. These are also policy systems. Public institutions are governed by legal frameworks which coalesce into sets of discourses, representations and practices with sociocultural implications. In Western Europe, public institutions are perceived as secular; where religion holds a role and a place, it is usually relegated to secondary positions and responsibilities. Public policy and policymakers refer to a

secular frame when negotiating claims to universality. The study of religion in sociology and political science has only recently started researching public institutions as sites where religion is represented and lived outside religious organizations. In this study, I attempt to breach into these questions.

I quickly realized that comparing three institutional settings and their policy systems would be unwieldy. It became apparent that the organization of strategic action fields within each system, the organizations comprising each system, and the trajectories, discourses, representations and practices pertaining to religion in each of those settings and policy systems would take more than a single doctoral dissertation. I turned to the healthcare system for three reasons.

First, there is sufficient research on healthcare in Western Europe: this allows scholars to search for religion in this institutional setting without having to reach milestones in basic research, but research volume is low enough to allow for significant gaps in the literature. This study attempts to fill one such, however small, gap.

Second, healthcare is one of the most complex enterprises in contemporary societies and its relationship to religion and religious organizations is ancient; indeed, institutionalized religion, as far as historical sources allow us, quickly grasped the significance of health and healthcare; many religious responses to life-related events are closely linked to health enhancement. Today, this relationship continues to be significant. In public hospitals, religion may have been redeployed in new guises and forms, but remains an important reminder of the social dimension of healthcare and health.

Third, healthcare as a social process is interesting for research purposes because it bears on basic theoretic questions. How do macroscopic processes and structures influence mesoscopic contexts and microscopic social interactions (Alexander 1987)? How does one single legal regulation impact lived religion in public institutions? Sociological discourse maintains a vivid debate around these questions. This study attempts to discuss these issues and look at multiple scales simultaneously.

The role and status of State-religion relations becomes a discussion point. The literature on this topic usually stresses rigid categories. The case of Portugal is illustrative: since a Concordat is in force, the country accommodates religion and enforces monopoly conditions in the religious field. The most systematic study on State-religion relations, by Fox (2008), goes a step further and disaggregates categories and regulatory mechanisms, but it falls short of providing policy-specific measurements.

The research questions imply an assumption: similar organizations should respond similarly to change and should go about changing in similar ways, given conditions of institutional isomorphism, But all three hospitals compared in this study depart from this assumption: there is little convergence in concrete religious assistance regimes, although a single religious assistance regime is legally enforced in Portugal.

1.3 The religious field in Portugal

The Portuguese religious field is defined by Catholic dominance and a four-tier hierarchical structure. I argue that the dominance of the Roman Catholic Church and Catholicism have partially produced a four-tier structure where distance to the dominant actor defines the position of any single religious tradition in a tier. These tiers are also defined by their claims to legitimacy. As such, so-called "world religions", including Buddhism, Hinduism, Judaism, Islam (Sunni and Shi'a Ismaili), are first-tier actors. Protestant congregations are relegated to the second tier because of their traditionally oppositional stance towards the dominance of the Roman Catholic Church. The third tier is taken by new religious movements seen within the religious field as non-oppositional or not threatening to the immanent order. This tier holds little consequence, for reasons that merit further explanation and support its inclusion as a logical remainder. Fourth-tier traditions are either new religious movements or religious traditions which are seen as oppositional and threatening. This tier includes neopentecostal congregations and Jehovah's Witnesses.

A field-theoretical description of religion in Portugal must follow the suggestions of recent work in field theory (Fligstein and McAdam 2012; Rey 2007). The religious field in Portugal can be fruitfully recast as a strategic action field. Incumbents, challengers and internal governance units should be described and categorized. The problem of social skill, political/organizational/institutional entrepreneurship should be faced in order to identify individuals and/or groups key to the structuration of the field. The broader field environment, namely its relations to other fields, should be understood, delimited and specified. Further, exogenous shocks, mobilization and episodes of contention are to be described and defined as such. Then, rules and settlements should be identified and included in the analysis.

I recast the Portuguese religious field along these lines because field-theoretical research holds the promise of streamlining units of analysis and enjoining them: strategic actions fields are

found in any instance or scale in human endeavors and fields are necessarily nested. Wards in hospitals are fields nested in and managed by hospitals, while hospitals are nested in a hospital network; a hospital network is nested in a health service, while a health service is nested in the policy system, all the way up to macro-level fields, such as society or the economy. If any actor in the religious field itself is properly understood as a collective endeavor, it is then a strategic action field itself and every applicable research procedure should be possible across scales and levels of analysis.

1.4 The public and the secular

Organizations are complex social formations structured around shared sets of rules which pursue one or more objectives. In the classic Weberian definition, an "organization is a system of continuous activity pursuing a goal of specific kind." (Weber (1962: 113). As it relates to healthcare, the transition between academic scholarship focused on systems analysis and organizational processes is aptly discussed in Lindberg et al. (2012: chapter 2). In this dissertation, organizations are bound to their environments in a recursive relationship mediated by institutions.

Organizational goals or objectives may be attained through division of labor within some institutional constraints. Religious diversity, as both a challenge and a societal feature, can be one of those constraints. But in some contexts, as shown in this dissertation, it may be perceived and used as a resource. This was the case in one of the hospitals studied for this dissertation. Liberal secularity operates as a paradox and public institutions, to the extent that they are formed in order to accomplish some goal, normally try to advance common good – and usually to advance its universal provision. With regard to religious diversity, our working hypothesis is that these institutions fall short of doing so because liberal secularity pushes religion into a discursive and political corner. Religion is not perceived as endogenous to public institutions; instead, it is perceived as one among many identities and religious diversity is perceived, as a consequence, as exogenous to public institutions. This is why it is also hypothesized that "accommodation" is variable not just according to "philosophies of integration" (Favell 1999), but to sector-specific organizational features of public institutions. The publicness of healthcare public institutions is one such feature; the specific goals of healthcare institutions are another. These features are seen in the hospital itself. Moreover, liberal secularity does not operate independently of context: there are myriad varieties of secularity and any attempt to generalize its regimes must recognize organization-specific features.

Secular formations in schools are different from secular formations in hospitals; secular formations vary from hospital to hospital based on organizational history, power structure and social-territorial location. One hospital founded during a regime of strict anti-clericalism in health policy-making will present different constraints and opportunities to religion when compared to a hospital operated by a Catholic order with public funding, even if both are now constrained by the same legal framework, the same financial controls and the pressure of institutional isomorphism (DiMaggio and Powell 1983). Isomorphism is defined as pressure to conform and converge into certain organizational forms and practices. Organizational responses should be similar within policy sector but different across them. These organizational responses are based on shared frames of reference, as suggested by DiMaggio and Powell. In the case of Portugal, the master frame is provided by the Constitution as it entered into force in 1976, which enforces "aconfessionality" – a notion which seems compatible with that of "areligious secularism" proposed by Sullivan (2005) - of the State and, by extension, all public institutions. Constitutional rules, as discussed below, are supplemented by a key legal bill, the 2001 Law on Religious Freedom, and intertwine with the 1975 amendment to the 1940 Concordat, which had been signed between the authoritarian Portuguese State and the Vatican as a signal of its recognition of the primacy of Catholicism in the Portuguese public sphere (Carvalho 2013). The 1940 Concordat was replaced by a 2004 update, which was deemed necessary in the context of the 2001 Law and unsolvable contradictions between State aconfessionality and Catholic exceptionalism. In 2009, the legal infrastructure was adapted to specific regulatory demands on religious assistance in three public institutional environments: the military, the healthcare system and the prison system. As will be shown, religious assistance in the healthcare system produced the highest level of policy conflict and media salience.

1.5 Public healthcare and religious assistance

Public healthcare provides health services to the general population. It is prevalent in most Western European polities and is one of the most important policy fields in welfare states. Its history and politics is the object of a voluminous literature. A broad overview is necessary because the provision of healthcare lies at the heart of State power.

Spiritual and religious care in hospitals is an organizational instantiation of State-religion relations' historical path dependencies. It is the provision of spiritual and/or religious care by chaplains or religious representatives, with or without certified training, to patients and staff within the organizational, institutional and cognitive constraints of hospitals. As an illustration,

State-religion relations in Portugal are instantiated in contemporary public hospitals through the continued dominance of Roman Catholic chaplains in the provision of religious assistance and official recognition of Catholic representativeness as a criterion for exceptions afforded to the Roman Catholic Church. Previously, the relationship between religion and healthcare was briefly mentioned. As hospitals transitioned into the State secular sphere, religion became a niche social world within the powerful logics of medicalization. Spiritual and religious care in hospitals is thus highly regulated, not only because its presence poses difficult questions to the publicness of public institutions but also because religion offers a complete and consistent narrative of the body and illness. This is an additional sense in which chaplains live at the margins of both their religious traditions and the public institutions they work in. However, there is another domain into which spiritual and religious care could be assigned: that of lived religion.

As shown below, lived religion is appropriate as a sociological concept to explain the social processes underpinning spiritual and religious care in institutional settings which are not themselves religious. It is not commonly used by chaplains or religious representatives because these individuals do not perceive religion as displaced; instead, they perceive religion as ever-present and as belonging in specific non-religious settings which are or have been, at some point, linked to religious communities. This is the case of healthcare. Therefore, lived religion in hospitals is an instance of displaced religion as well. Lived spirituality is also a research problem, as pointed out by Cadge and Sigalow (2013), Lee (2002) or Norwood (2006); individuals who perform religious assistance engage in framing strategies which lead religion in hospitals out of the institutionalized realm into neutralizing or code-switching strategies (Cadge 2013, Cadge and Sigalow 2013). The unexpected finding, in this study of strategies identified in American contexts, is striking. As argued above, the very notion of spiritual and religious care or assistance is likely to depend on displaced religion. The concepts of visitation and chaplaincy are foundational to displaced religion, as these were the initial formulations through which institutionalized religion in Europe sought to move beyond religious space. Religious organizations are primarily geared towards spiritual and religious care; religious assistance comes into existence, one could argue, when the space where it eventually exists is seen as lacking something – it is in that sense that Winnifred Fallers Sullivan speaks of the chaplain's function as "she operates at the intersection of the sacred and the secular, a broker responsible for ministering to the wandering souls of a globalized economy and a public harrowed by a politics of fear—while also effectively sacralizing the institutions of the contemporary world." (Sullivan 2014, loc:65-66). Displaced religion is thus the whole of

representations and practices construed as religious outside those institutional instances which are foundationally religious. A case in point is hospitals or any other organizational context where religion is not the core function.
This study looks at individual and organizational experiences as producers and products of local negotiated orders; it is located in a national context. It is comparative because it attempts to align three organizational contexts which developed and operate in a single regulatory, normative and cultural-cognitive context.

Religious assistance in hospitals is not easily framed by existing theoretical frameworks. Further, religious assistance in care institutions has not been discussed extensively in the literature. The juxtaposition of religious and spiritual assistance is one of the consequences. Religious and spiritual assistance are two entangled but different modes of existential, non-medical care. Religious assistance pertains to assistance offered by certified religious representatives grounded in the need (perceived by representatives and/or patients) for care based in religious worldviews. Spiritual assistance is a higher-order practice because it encompasses religious assistance and other forms of non-religious existential care. However, as suggested above, the Portuguese context is an instance of not only conceptual but also legal and organizational juxtaposition: there is no tangible difference between spiritual and religious assistance in Portuguese public hospitals.

1.6 Chapter sequence

This dissertation is structured around the following sequence. The next chapter details scope conditions for case selection, the national context and the cases selected on the basis of previously specified scope conditions. It then details the Portuguese national context in terms of its religious dynamics and its healthcare policy process. Chapter 3 introduces strategic action field theory and the organizational analysis of hospitals. As regards the former, two concepts are highlighted: strategic action fields (SAFs) and agency within fields. As regards the latter, the hospital is defined, for the purposes of this study, as a professional bureaucracy. Chapter 4 reviews existing literature on State-religion relations, namely the 2001-2009 period, the politics of hospital governance in Portugal and the role of religion in public institutions, particularly healthcare-producing organizations such as hospitals. The issues of biomedicine, medicalization and organizational secularity are surveyed and discussed. Chapter 5 introduces the cases and provides historical detail into the Portuguese religious field, particularly contemporary developments in the religious field and its connectedness to healthcare. The

policy process of the 2009 Regulation on Spiritual and Religious Care in Hospitals is described and discussed. The emergence of a multi-faith initiative on health is discussed as a result of the post-2009 configuration in the religious and healthcare policy fields. It then proceeds to describe the historical development of healthcare in Portugal and the role of hospitals in the provision of healthcare. Chapter 6 is a description of each selected case: the staff structure of each hospital is detailed with particular focus on three specialties, psychiatry, internal medicine and general/family medicine, which are relevant in terms of the position of religious assistance in Portuguese public hospitals.

CHAPTER 2: Case Selection and Data Collection

This chapter has three objectives. First, it details the research design that led to the stipulation of Portugal and public, high-end hospitals, respectively as a relevant national context and relevant organizational cases in terms of the questions posed in the previous chapter. Second, it discusses method selection and methodological procedures in terms of what this dissertation aims to achieve – answers to questions and theory development on the basis of those answers. Third, it describes and discusses data collection.

2.1 Research design

Research design and case selection procedures are two important procedures in case-oriented research. As established in case-oriented methodological guidelines, research design refers to the structure of the research procedure itself. In addition, it refers to the strategy employed by the researcher in establishing the "domain of investigation" and to the steps taken towards case saturation, where no additional leverage on the case can be gained through research. In qualitative research, case saturation is indicative and not precise: the researcher must decide at which point her knowledge of cases is sufficient to make appropriate inferences and start the theory development process. In most qualitative research, case saturation is not achieved because social life is perceived as complex, emergent and to some extent unpredictably connected. This dissertation strives for balance between case saturation and explanation.

2.2 Scope conditions for case selection

Case selection follows from research design choices. Research design choices are conditions which follow from research questions into the selection of appropriate cases within a domain of investigation. These choices follow from two steps: establishing clear scope conditions for the selection of cases – both unit-wise and timeframe-wise – and defining the approach through which cases are paired. Cases in this dissertation are most-similar systems – the organizational cases of public, high-end Portuguese hospitals – chosen within a single context, the Portuguese national case, in order establish clear scope conditions, a definition of which has been provided above.

In the introductory chapter, we presented three research questions.

1. Why do healthcare public institutions facing similar regulatory constraints show different patterns of religious assistance?
2. How do religious representatives act upon perceived constraints in terms of their lived religious experiences?
3. How does instability transfer from one strategic field to another (in this case, from the religious field to the healthcare policy field)?

Scope conditions can be defined in order to answer these questions. Question #1 determines that organizational cases must face similar regulatory constraints and must offer some form of religious assistance. This narrows the scope of eligible cases in the complete set of "healthcare institutions".

First, only public institutions are regulated according to a broadly similar set of regulatory standards. The issue here is the degree of similarity. It is likely that private institutions operate according to different guidelines and benchmarks; they do not necessarily operate religious assistance services, as is required of public institutions. For this reason, and in order to narrow down eligible cases, the domain of investigation comprises public hospitals, not private or a mix of public-private ownership. In the following chapter, this choice is discussed as a result of State-religion relations in Portugal and the importance of religion in the healthcare policy field.

Second, healthcare public institutions must face similar regulatory constraints. As such, they must be close to each other in terms of their position in the Portuguese healthcare system and in terms of their organizational structure. High-end acute care hospitals in Portugal share many similarities. These are organizations which closely resemble one another to a degree not observable in other healthcare organizational groups. Regional hospitals, specialist hospitals and local health centers may be condensed into single categories, but they differ widely regarding their position in the healthcare system and the population they serve. High-end hospitals in Portugal are located in densely populated urban environments where religious dynamics tend to share similarities and where religious diversity is higher than in smaller urban or rural environments. Furthermore, these organizations face different regulatory challenges even when they share the same category: two hospitals may operate under public ownership and management, but their rankings and specialties may make them sensitive to different sets of regulatory arrangements. As an example, cases selected for this dissertation operate under the same regulatory standards and requirements, but a district hospital, while public, does not operate under similar standards and requirements. This is because their geographical location

is more important in the determination of their organization structure than to high-end hospitals.

Third, some form of permanent, publicly-supported religious assistance must be offered. This is not the case in local health centers, which do not pay religious representatives. As local health centers do not lodge patients for surgery or other long-term care, regulations do not include those organizations in the set of healthcare venues mandated to provide religious assistance. These organizations are not mandated to support religious traditions even though they are also not allowed to prevent their representatives from entering premises. There are religious assistance services in these local organizations, but they are not paid for with public outlays. Religious assistance is most prominent in high-end hospitals; these are large organizations which cater to the needs of large populations.

2.2.1 Case selection

Following the definition of scope conditions, we move to case selection. This discussion proceeds in two steps. First, the choice of Portugal as a relevant national context is introduced. The context itself is described in more detail in chapter 4. Second, the choice of high-end public hospitals is also introduced and justified.

The choice of Portugal as a relevant national context among eligible alternatives in Western Europe is justified in this dissertation on two bases. One concerns research gap identification. The other concerns relevance to the research questions introduced in the previous chapter. We take these in turns.

2.3 The Portuguese case in comparative perspective

The Portuguese case was selected from the universe of European countries with high-end public healthcare institutions. The national case of Portugal is part of a set of Southern European countries where the religious field operates under monopolistic or quasi-monopolistic conditions. As other Southern European countries, this is a case where the migration transition moved at a comparatively later stage than Northern and European cases: net migration rates increased significantly in the 1990s as large inflows from Portuguese-

speaking countries and labor migration from Eastern European countries came to redefine the configuration of social and religious diversity in Portugal. This is illustrated by the demographic significance of a single religious tradition and by the preferred status accorded to its institutionalized instances.

Table 1 reports models of State-religion relations as defined by Fox (2008).

Table 1. Government Involvement in Religion category definitions

Specific Hostility: Hostility and overt persecution of religion where state ideology specifically singles out religion in general or religion is in some other way uniquely singled out for persecution (i.e., the ex-U.S.S.R.)
State Controlled Religion, Negative Attitude: The state controls all religious institutions and discourages religious expression outside of those institutions. This is part of the state's policy of maintaining social control or keeping religion in check rather than due to the ideological support for religion.
Nonspecific Hostility: While the state is hostile to religion, this hostility is at about the same level as state hostility to other types of non-state organizations. Religion is not singled out.
Separationist: Official separation of Church and state and the state is slightly hostile toward religion. This includes efforts to remove expression of religion by private citizens from the public sphere.
Accommodation: Official separation of church and state and the state has a benevolent or neutral attitude toward religion in general.
Supportive: The state supports all religions more or less equally.
Cooperation: The state falls short of endorsing a particular religion but certain religions benefit from state support more than others. (Such support can be monetary or legal.)
Multi-Tiered Preferences 2: Two or more religions are clearly preferred by state, receiving the most benefits; there exists one or more tiers of religions which receive less benefits than the preferred religions but more than some other religions.
Multi-Tiered Preferences 1: One religion is clearly preferred by state, receiving the most benefits; there exists one or more tiers of religions which receive less benefits than the preferred religion but more than some other religions.
Preferred Religion: While the state does not officially endorse a religion, one religion serves unofficially as the state's religion receiving unique recognition or benefits. Minority religions all receive similar treatment to each other.

Historical or Cultural State Religion: There is an official religion but it is mostly due to historical or cultural inertia.
Active State Religion: State actively supports religion but the religion is not mandatory and the state does not dominate the official religion's institutions.
State Controlled Religion, Positive Attitude: The state both supports a religion and substantially controls its institutions but has a positive attitude toward this religion.
Religious State 2: Religion mandatory for members of official religion
Religious State 1: Religion mandatory for all

Source: Fox (2008:loc1100; 2015)

In the Western democracies cluster, no national case is categorized in the "Specific Hostility"-"Non-specific Hostility" categories or the "State Controlled Religion, Positive Attitude"-Religious State 1" categories. Instead, all 27 national cases are categorized in between. In Western Europe, 23 national cases are reported by the Religion and State Database (Fox 2008; 2015) as having remained in the same category for the period 1990-2008. Austria, Luxembourg Portugal and Sweden are the four reported cases within the Western Democracies cluster of the Religion and State Database (Fox, 2008) as having changed their regimes of Government Involvement in Religion in the same period. The relevance of Portugal as a specific national case lies in its transition from a Preferred Religion model to a Multi-Tiered Preferences 1 model; it is the single case in the cluster where State-religion relations show a decrease in State preference for one religious tradition. The multi-Tiered Preferences 1 model in Portugal shows a high level of continuity with the Preferred Religion model: as argued in this dissertation, legal transition did not translate into a playing field where the State shows multi-tiered preference for a significant number of religious traditions; however, it is the case that, with regard to the pre-2001 established framework, significant change was legally enforced. The case of Sweden, as it transitioned from an Active State Religion model to a Cooperation model, is the only other case where State preference for a specific religious tradition has transitioned into a more pluralistic model. This is an argument for holding the Portuguese case as a "natural experiment" of sorts. In 2001, the Law on Religious Freedom entered into force as the dominant settlement in the religious field came into question, but it fell short of completing separation, as is written in the legal bill. The French model is traditionally seen as exemplary in its enforcement of separation, but the Portuguese case is shown to be closer to its Southern European counterparts, where the Multi-Tiered Preferences 1 model is now dominant.

The Portuguese case shows lower levels of religious legislation than most cases in the cluster of Western Democracies but it is not an outlier in Southern Europe, where levels of religious regulation are low when compared to France, Germany or the United Kingdom. The case of Portugal shows lower levels of religious legislation than most Western democracies and all Southern European cases with the exception of Malta. The level of discrimination against minorities is shown by the RAS dataset in Portugal as lower than all other Southern European cases with the exception of Andorra. Restrictions on access to public venues by minority clergy and the Portuguese case fits into the dominant category. However, as reported in Chapters 5 and 6 of this dissertation, while formal restrictions were low or non-existent, actual restrictions existed and remain in force, at least in the case of public hospitals. The Religion and State Database is thus an important framing tool, but requires careful reading and interpretation, at least in the case of Portugal.

An important caveat to the State-religion relations institutional arrangement in Portugal is reported by Fox (2008: loc2619): along with the United States of America and France, the Portuguese Constitution provides for official separation between Church and State but does not present additional detail on the modes of separation. Furthermore, it is the only such Constitution to provide for aconfessionality and coexist with legal provisions for the establishment of a preferred religion regime. Changes in this environment from 2001 have not reconfigured State-religion relations to a significant extent. The case of Portugal fits the above-mentioned "natural experiment" proposal. From 1990 (and before) to 2001, Portuguese State-religion relations were relatively stable and levels of religious legislation or regulation support the identification of stability. As the 2001 Law on Religious Freedom entered into force, the religious field entered a transitional phase which largely remains in play. Measures of religious legislation do not necessarily capture the opening of critical junctures. The effect of the 2004 Concordat is not captured in those measures; it is show in this dissertation that the transition started in 2001 remained in play until at least 2009, as regulatory standards on religious assistance entered into force.

Table 2. Government Involvement in Religion (1990 or earliest-2008)

Country/Year	1990 or earliest	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Andorra	Preferred Religion																			
Australia	Accommodation																			
Austria	Cooperation										Multi-Tiered Preferences 2									
Belgium	Cooperation																			
Canada	Accommodation																			
Cyprus, Greek	Multi-Tiered Preferences 2																			
Cyprus, Turkish	Preferred Religion																			
Denmark	Active State Religion																			
Finland	Active State Religion																			
France	Separationist																			
Germany	Cooperation																			
Greece	Active State Religion																			
Iceland	Active State Religion																			
Ireland	Preferred Religion																			
Italy	Multi-Tiered Preferences 1																			
Liechtenstein	Active State Religion																			
Luxembourg	Supportive										Cooperation									
Malta	Active State Religion																			
Netherlands	Accommodation																			
New Zealand	Supportive																			
Norway	Active State Religion																			
Portugal	Preferred Religion												Multi-Tiered Preferences 1							
Spain	Multi-Tiered Preferences 1																			
Sweden	Active State Religion											Cooperation								
Switzerland	Cooperation																			
UK	Historical or Cultural State Religion																			
United States	Accommodation																			

Source: Religion and State Database, Fox (2008)

Table 3. Religious regulation (1990 or earliest-2008)

Country/Year	earliest	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Andorra	1																			
Australia	0																			
Austria	2																			
Belgium	2																			
Canada	2																			
Cyprus,	3																			
Cyprus,	5																		4	
Denmark	2																			
Finland	5											2								
France	6															10				
Germany	9																			
Greece	10									8										
Iceland	4									3										
Ireland	2																			
Italy	2																			
Liechtenstein	4																			
Luxembourg	1																			
Malta	0																			
Netherlands	3																			
New Zealand	0																			
Norway	4																			
Portugal	3																			
Spain	0																		1	2
Sweden	8	11										2			4					5
Switzerland	12												10	8						
UK	6																	10		
United States	1																			

Source: Religion and State Database, Fox (2008)

Table 4. Religious legislation (1990 or earliest-2008)

	1990 or earliest	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Andorra	4																			
Australia	3																	4		
Austria	4																			
Belgium	8																			
Canada	7		6																	
Cyprus, Greek	9									8										
Cyprus, Turkish	5																	4		
Denmark	12																			
Finland	11																			
France	7																			
Germany	11														12					
Greece	14											13			14			13		
Iceland	9																			
Ireland	7																			
Italy	5						6													
Liechtenstein	3																2			
Luxembourg	4									5										
Malta	5	5	6																	
Netherlands	4																			
New Zealand	5																			
Norway	10																			
Portugal	5																			
Spain	10																			
Sweden	13												11							
Switzerland	12														11					
UK	11		10														11			
United States	1												2		3					

Source: Religion and State Database, Fox (2008)

Table 5. Discrimination against minorities (1990 or earliest-2008)

Country/Year	1990 or earliest	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Andorra	0																			
Australia	1																			
Austria	11												12			13				15
Belgium	9								12		13				14		15	16		
Canada	0																			
Cyprus, Greek	4																		3	
Cyprus, Turkish	8																			
Denmark	4															6				
Finland	1										2							3		
France	9						10		13				14		15					
Germany	19														20		21			22
Greece	16																	15		
Iceland	4																			
Ireland	0																			
Italy	3										4						5			
Liechtenstein	1																			
Luxembourg	2																			
Malta	0																		1	
Netherlands	1																			
New Zealand	0																			
Norway	6																		8	
Portugal	0																			
Spain	5		6							7										
Sweden	5										8		9			10			9	10
Switzerland	10						12				13		15		16	17	18		17	16
UK	3																			4
United States	1																			

Source: Religion and State Database, Fox (2008)

Table 6. Restricted access of minority clergy to hospitals, jails, military bases, and other places of worship (1990 or earliest-2008)

Country/Year	1990 or earliest-2008
Andorra	Not significantly restricted for any minority
Australia	Not significantly restricted for any minority
Austria	Not significantly restricted for any minority
Belgium	The activity is slightly restricted for most or all minorities or sharply restricted for some of them
Canada	Not significantly restricted for any minority
Cyprus, Greek	Not significantly restricted for any minority
Cyprus, Turkish	Not significantly restricted for any minority
Denmark	Not significantly restricted for any minority
Finland	Not significantly restricted for any minority
France	The activity is slightly restricted for most or all minorities or sharply restricted for some of them
Germany	The activity is slightly restricted for most or all minorities or sharply restricted for some of them
Greece	The activity is slightly restricted for most or all minorities or sharply restricted for some of them
Iceland	Not significantly restricted for any minority
Ireland	Not significantly restricted for any minority
Italy	Not significantly restricted for any minority
Liechtenstein	Not significantly restricted for any minority
Luxembourg	Not significantly restricted for any minority
Malta	Not significantly restricted for any minority
Netherlands	Not significantly restricted for any minority
New Zealand	Not significantly restricted for any minority
Norway	Not significantly restricted for any minority
Portugal	Not significantly restricted for any minority
Spain	The activity is slightly restricted for some minorities
Sweden	Not significantly restricted for any minority
Switzerland	Not significantly restricted for any minority
UK	Not significantly restricted for any minority
United States	The activity is slightly restricted for some minorities

Source: Religion and State Database, Fox (2008)

The case of Portugal shows some important specificities. In 1911, the First Republic, an explicitly anticlerical elitist republican regime, curtailed freedom of religion and attempted to enforce an assertively secularist rule of law. This included the evacuation of religious symbols from all public institutions and the implementation of various public policy programmes intended to compensate for the monopoly of Church-related associative bodies in service

provision. As a consequence of these policy priorities, severe instability brought the republican regime to an end by 1926. In 1933, a corporatist regime enacted authoritarian reforms which reinstated the role of the Roman Catholic Church and, eventually, signed the first of two Concordats in 1940. In 1975, as the transition to democracy took place, the Concordat was amended in order allow for civil divorce, which had been outlawed previously.

In terms of health provision, the case of Portugal is of particular interest because healthcare is traditionally a matter of public significance and, until recently, the object of near-monopoly by the State. The most significant exception lies in the network of Roman Catholic-sponsored institutions which has historically provided for healthcare and medical education.

2.3.1 The national context

The case of Portugal was selected because there is comparatively little research on Portuguese State-religion relations. The literature on comparative State-religion relations in Western Europe is large and there are several important case-based works, but there are few monographs on the Portuguese case. There is an identifiable research gap. While this is explainable, it nevertheless opens up an interesting opportunity for research efforts which focus on the Portuguese case. Furthermore, this is a case which has faced important recent developments in State-religion relations. In 2001, a legal bill redefined State-religion relations and forced a revision of the Concordat between the Portuguese State and the Vatican, which had been in force since 1940 with important amendments in 1976. The revision was concluded in 2004. In 2009, both the 2001 bill and the 2004 Concordat revision originated specific regulations on the presence and management of religion in public institutions, namely hospitals, prisons and military facilities. This is relevant to case selection. Portuguese State-religion relations have changed fundamentally in the span of a single decade. Regulatory constraints have been imposed to public institutions and strategic responses by those institutions are expected. Moreover, this allows us to ask important questions with regard to our second and third research questions. How does institutional change in State-religion relations impact actual, lived religion? There is now sufficient distance from 2001 to enable research into this topic, but not so much that first-hand reports are difficult to find. In addition, when we describe the Portuguese religious field during the 2001-2009 period, it becomes apparent that instability was a key feature in its dynamics. Has that instability trickled into the healthcare policy field? Religious assistance in healthcare settings is the link between both fields and has changed in this period as well.

2.4 Choosing organizations

The three organizational cases chosen for the purpose of investigating the questions posed in the introductory chapter are A1-class general central hospitals as defined by the Portuguese SNS. All three are top-tier facilities regarding budget, staff and medical specialties. These are the three largest public hospitals in Portugal with very large target urban populations. Furthermore, these are university hospitals.

The choice of organizational cases started from a concrete definition of the universe of cases. This set is the set of public healthcare venues in Portugal. These include local health centers, regional hospitals, specialty hospitals (orthopedic and oncological) and small general hospitals. The Portuguese SNS is arranged along two cleavages: geographic coverage and organizational specialization. By definition, local health centers offer very little medical expertise as compared to specialty hospitals and cover very limited populations. Small general hospitals are spread over Portugal in order to provide a mix of general and specialty care. The healthcare landscape in Portugal suggests that organizational similarity, if it is to be found at all, is more likely to lay at higher levels of specialization and larger population coverage. Those facilities that offer more specialized care and serve larger populations are more likely to be similar in their structure than their lower-end counterparts.

We can thus limit our sample to high-level hospitals, namely those categorized in the Portuguese SNS as A1-class hospitals. In chapter 4, further detail is offered on the specifications of the A1 category. For the purposes of case selection, it is sufficient to state that A1-class hospitals are located in urban contexts which increase population diversity and force them to comply both with regulatory demand for religious assistance provision and patient demand for religious assistance services. In addition, it is likely that these hospitals need to negotiate religious diversity in some form, because, where religious diversity exists in Portugal, it is likely to be salient in urban contexts. It would be unlikely that patterns of religious assistance would show divergence if there were no social process leading organizations to react.

Among these high-level facilities, a limited number lodges medical colleges affiliated with public universities. As detailed in following chapters, university hospitals differ from their non-

university counterparts in at least three ways regarding the pattern of religious assistance. Religion is not beneficial to the position of religious representatives in teaching hospitals because these institutions are incentivized to pursue knowledge production which excludes religion and spirituality as a viable discourse or basis for care.

First, university hospitals' functional structure is different. If religious assistance services are part and parcel of hospital structures, the broad structural form of these institutions should exert an impact on how religious assistance is provided in a university hospital as opposed to non-university hospitals. It also suggests that a comparison of university hospitals is helpful in enhancing comparability because their teaching function is another convergence vector. The question then becomes why such hospitals show different patterns of religious assistance. Given that teaching hospitals are not only in charge of care and cure of patients, but also teach medical students, they should react more similarly (to another) to regulatory constraints than is the case among all high-end hospitals. The presence of students in hospitals creates similarities as regards the management of religious diversity for two reasons. Religious assistance itself is affected by the increased status given to technology-heavy specialties, which are sought by students and decreases the status of those medical specialties which are most likely to support religious assistance – psychiatrists, internists and general/family practitioners; in this case, religious diversity is not a valuable resource to religious assistance because it does not guarantee survival. The presence of students stimulates this: university hospitals are likely to be less accommodating to religious assistance because students are likely to be more interested in developing technologically demanding specialties than in lower-ranked specialties. Although increased diversity in hospitals entails increased religious diversity, the structure of religious belief in Portugal shows that younger cohorts are less inclined to express religious belief and more inclined to report no religious belief. This makes religious diversity less appealing to religious assistance services than an investment in its transition into an adapted hospital support service.

Second, university hospitals' power structure is different from other high-end hospitals. In teaching hospitals, differentiated specialists, such as neurosurgeons or oncologists, are afforded more opportunities to attain and hold power because these hospitals offer acute and specialty care which is unique in the country. Internists are not valued because their contribution to cure output is indeterminate– the ability to show that their specialty is useful to increase hospital performance. Modern medical knowledge is an important factor in distributing power among medical professionals. Medical specialists are more sought after by students than other medical professionals: specialization is perceived as a career-enhancing and financially rewarding

move. Further, the importance of knowledge and differentiation in these hospitals, as opposed to other high-end hospitals, affords teaching medical professionals more power in relation to other groups in the organizational structure. Because their power as teachers accrues to their power as medical professionals, given that their former role derives from the latter, their independence in relation to administration staff and support staff is enhanced. If the literature on professional power in hospitals is to be taken as correct, the position of religious assistance services in these hospitals is, at the outset, probably more convergent than in other hospitals. Chaplains and religious representatives are unlikely to be afforded much significance in these hospitals to extent that their professional power is actually diminished by their symbolic power. Third, university hospitals show specific discursive patterns. Because their teaching function is part of their overall structure, and medical teaching is both ideological and empirical, these hospitals are likely to pursue specific discursive goals. In modern medical knowledge, medical doctors and the range of disciplines that form modern medicine are technoscientific in their means and biomedical in their ends. In other words, technology is equated to treatment and material cure is regarding as the only desirable outcome. As mentioned above, medical specialists are more powerful than medical generalists – an assertion which is especially valid to teaching hospitals. Medical specialists are consistently more reliant on technology-heavy care and put more emphasis on cure than other medical professionals. In Portuguese hospitals, palliative care is recent as a recognized discipline. Internists, who focus on preventive and general medicine, are less powerful. This has important potential consequences for religious assistance. Where the literature suggests some cooperation between medical professionals and religious representatives in hospital contexts (Cadge 2013), this is limited to internists, psychiatrists and nurses. Importantly, these categories are those least theoretically concerned with the technoscientific-biomedical ideology. Internists tend to pursue preventive care and whole-person approaches; psychiatrists tend to value religious approaches to patient psychology for their palliative effects; nurses are less concerned with cure than with care. In teaching hospitals, none of these categories are powerful enough to generate opportunities for religious assistance. In effect, technoscientific-biomedical discourse is an attempt to take medical care from pre-modern belief to modern rationality. Religion is unlikely to be perceived as legitimate in these contexts. But it also forces religious representatives to react or risk exclusion. For the purposes of this study, this is an important factor because it positions religious assistance as dynamic. As suggested above, recent changes in regulatory constraints suggest that, while previously static – as the regulatory framework had remained unchanged -, religious assistance has entered a state of flux.

This study deploys a most-similar systems research design. In Chapter 6, I describe the three cases (Hospital A, Hospital Band Hospital C) analyzed in this study.

2.5 The case study method

This dissertation is a comparative case study of religious assistance in three public, university high-end Portuguese hospitals. In this section, the case study method is specified in detail. As it is a complex method, with several definitions, specifications and conditions, we focus on the multi-case study, the pairing of cases and the strategy of structured, focused comparison. A detailed discussion on the status of cases is held in order to establish how cases were found and assembled. Then, the technique of process-tracing is specified in order to argue for its centrality in this study and to describe its procedures.

Comparative case studies are paired comparisons in the sense that a low number of cases is compared as a procedure to understand or explain any given phenomenon. Yin states that "a case study is an empirical enquiry that investigates a contemporary (sic) phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (2014:13). Ragin adds that cases are "complex configurations of events and structures" (2004: 125), constituted before, during and after research. This study was built in accordance with that iterative logic and the precepts of structured, focused comparison, as suggested by Bennett and George (2006). What is a case? We start from two definitions. Gerring states that "Case connotes a spatially delimited phenomenon (a unit) observed at a single point in time or over some period of time. It comprises the type of phenomenon that an inference attempts to explain." (Gerring 2007: 19), while Bennett and George "define a case as an instance of a class of events. The term "class of events" refers here to a phenomenon of scientific interest (…)" (Bennett and George 2005: 17). Both definitions allude to the case as an analytic unit that presents some discernible difference from its surrounding environment. Importantly, Bennett and George define cases as instances of classes of events: there may be whole populations of instances of classes of events, allowing for systematic, structured comparison. First-generation case studies tended to particularize excessively, thus inviting critiques such as those of Lijphart (1971) or Campbell (1970); second- and third-generation case study methodologists, by imposing stricter requirements on case study method usage, have largely surpassed traditional critiques. The question of whether these methods are able to concretely go beyond the "small-N, too many variables critique" remains open, but as

suggested in Collier and Brady (2010) and as evinced by the emergence of mixed methods and quali-quantitative comparison, or QCA (Ragin 2008), one may suggest that the strength of case study research is no longer in question; it is rather a matter of calibration than one of legitimacy. As suggested by Yin, case studies are especially useful in contexts where background conditions are not easily discernible from what the researcher seeks to study. But, as Creswell adds, a case is "(…) a real-life, contemporary bounded system (a case) or multiple bounded systems (cases) over time" (Creswell 2009: loc2092). The bounded character of cases, as well as its belonging to a larger domain or universe – the whole population of cases – is foundational to contemporary case study research, particularly comparative case studies.

What is the case study method? It is a class of methods which treat cases as its fundamental unit of analysis and approaches social processes as irreducible to cause-effect relations; moreover, these methods are intensive, which is to say that researchers doing cases studies prefer to gain leverage over their units of analysis in order to appropriately differentiate between background conditions, cases and each case. Nonetheless, all case studies apply a measure of comparison: when a researcher strives to characterize a case, she either seeks categories found elsewhere in the case universe, constructed by other researchers or constructed during her own research. The primary objective is to shed light on the case itself. This is why Gerring writes that "A case study may be understood as the intensive study of a single case where the purpose of that study is – at least in part – to shed light on a larger class of cases (a population)." (2007: 20). A case study is always intensive and at least partially focused on generalization. Bennett and George go a step further and state that the case study is an "approach – the detailed examination of an aspect of a historical episode to develop or test historical explanations that may be generalizable to other events" (2005: 5). In this definition, we see that generalization becomes the ultimate goal of case studies; this is disputable, as much anthropological and comparative historical sociological research shows. But it is a valid methodological point. Yin suggests that the case study is "(…) an empirical inquiry that investigates a contemporary phenomenon within its real-life context" (2014: 23). The case study is thus an empirical investigation of a unit within a concrete context. Case studies are not large-N studies where the causal nexus is an abstraction constructed for the purpose of model estimation.

As a method, the case study is connected to its ultimate objectives. In that sense, it is more important to discuss what the case study attempts to do than what it actually is. Gerring is especially useful in this regard, as a number of potential objectives is provided. The case study

may be hypothesis-generating; it may provide for internal case validity verification; it may allow for causal mechanism analysis; it pursues in-depth research (small-N, large number of observations); it allows for the analysis of heterogeneous populations and/or crucial cases (2007: Chapter 3).

Becker (2012), for instance, tends to prefer "how" questions, even if case study research tends to veer towards "why" questions. Bennett and George also contest the hypothesis-testing dominant paradigm, as case studies are especially important in hypothesis generation and theory development.

2.6 Data collection

Data collected procedures followed case study procedures. As a comparative study of religious assistance in Portuguese public, high-end university hospitals, research was arranged into four stages.

1) Desk research on national context: First, desk research reconstructed the national context in terms of its religious field and its health policy field, particularly the regulatory framework of religious assistance in healthcare. Existing literature on the religious field was surveyed. It is presented and discussed in chapter 4 as an overview of State-religion relations in Portugal. Statistical data were compiled so as to determine the composition and structure of the religious field. The most important data source in this regard is the Portuguese National Statistics Institute (NSI). The 1991, 2001 and 2011 census included one question on religious affiliation. These are used in this dissertation so as to reconstruct recent historical trends as regards religious affiliation in Portugal. As complements to NSI data, data was gathered from all European Social Survey waves since 2002 in module "Subjective well-being, social exclusion, religion, national and ethnic identity", from European Values Study waves since 1990 in module "Religion and Moral" and from International Social Survey Programme studies, namely the 1998 Religion I and 2008 Religion II modules. Variable observations capturing religious affiliation and belief were compiled. Historical and sociological literature on religion in Portugal was gathered and systematized in order to advance a structural, field-theoretical interpretation of the Portuguese religious field.

2) Desk research on the health policy field: Second, the health policy field necessitates a different data gathering strategy because there are no extensive data sources. As such, data gathering focused on written documents and reports, particularly those focusing on the Portuguese SNS structure. in order to reconstruct the position of hospitals within the system, hospital data was retrieved through database research (namely the World Health Organization Health-for-All Database the World Health Organization Regional Europe Office Health Systems in Transition report, OECD Health-at-a-Glance data and Eurostat data), specific hospital data analysis through the Portuguese Statistics Institute Hospital Survey, Homogeneous Diagnosis Groups' Surveys, Directorate-General of Health compiled statistics, Health Service Central Administration statistics and hospital *tableaux de bord*, annual reports and audit reports.

3) Desk research on policy process: Third, these initial procedures allowed for the identification of two processes which guided later fieldwork. These processes are the policy process of religious assistance regulation and, as follows from our first research question, the dynamics of patterns of religious assistance in Portuguese public, high-end hospitals. In order to trace the policy process, all relevant legislation was compiled. Three daily news and one weekly news outlets were surveyed in order to identify relevant developments and map potential informants. The three daily news outlets were Público (2003-2014), Diário de Notícias (2003-2014) and Jornal de Notícias (2003-2014). The weekly news outlet was Expresso (2003-2014). These outlets were surveyed in archives (Hemeroteca Municipal de Lisboa) and, where available, online archives.

4) Field Work (interviews): After the initial procedure, a list of informants was drafted and fieldwork was planned. Semi-structured interviews were planned according to two guidelines. Guideline I is the interview protocol for religious representatives, while Guideline II shows the interview protocol for policy officials.

Interviewees were selected based on their participation within religious communities and their stated and perceived commitment to health issues. Their participation in an informal discussion group on religion and health, which resulted in a number of initiatives and events, was the proxy used to judge their commitment. Interviews were conducted with representatives from the Roman Catholic Church, the Israelite Community, the Baha'i Community, the Ismaili Community, the Sunni Muslim Community, the Hindu Community, the Seventh Day Adventist

Church, the Evangelical Alliance, the Portuguese Council of Christian Churches, the Jehovah's Witnesses' Association and the Buddhist Union. As regards the Roman Catholic Church, the Health Pastoral coordinators were interviewed. Three head chaplains from each of the hospitals studied in this dissertation were interviewed. Two of them were interviewed twice for clarification using the same guideline. These interviews were complemented by interviews with two assistant chaplains. Observational fieldwork was conducted at each hospital for a period of one week in each site, where mass was attended. Fieldwork was also conducted in Fátima during the first training course for religious assistants, where forty individuals attended. Informal interviews were held with a military chaplain and four healthcare chaplains. This makes for a total of 22 interviews.

As regards the policy process, interviews were conducted with two former Health Ministers, one Health Secretary and three representatives from the National Council for Ethics in Life Sciences. In addition, an interview was conducted with the interim President of the Commission for Religious Freedom in addition to email clarifications requested to Chairmen of the Boards, Clinical Directors and Nursing Directors of the three hospitals, the Commission on Religious Freedom, the Ministry of Health, the Directorate-General on Health and the National Institute of Health. Where representatives were unavailable or unaccounted for, additional archival research was conducted; access to high-level State officials, high-level Roman Catholic Church representatives and New Religious Movement representatives was notably difficult.

Interview materials were analyzed in order to ascertain the development pattern of each religious assistance service using 2009 as a critical juncture. Because regulatory constraints changed markedly from 2001 to 2009, interviews allowed for case-based examination of convergence and divergence among religious assistance services, particularly as regards the emergence of religious diversity as the fundamental driver of change in religious assistance in hospitals.

CHAPTER 3: Theory

3.1 Introduction

In this chapter, two theoretical approaches are discussed. First, field theory is explicated in its modified form as proposed by John Levi Martin (2011) and, more importantly, by the seminal work of Fligstein and McAdam (2011, 2012). In an important reformulation of field theory as initially applied to the social world by Pierre Bourdieu (1971), strategic action field theory is a theory of social action which emphasizes positionality, strategy and agency. As formulated by Fligsten and McAdam, Strategic Action Field (SAF) theory stresses seven elements:

1. Fields. In SAF theory, fields are sites of strategic action; they are, primarily, sites of collective strategic action.
2. Actors. In SAF theory, actors are social agents in three categories: incumbents, challengers and governance units.
3. Agency. In SAF theory, agency is explained by meaning-making functions (what Fligstein and McAdam name "the existential function of the social) and social skill (what may be described as cognitive and discursive capacities). Field dynamics and patterns, such as hierarchies, coalitions, monopolies or oligopolies, are emergent products of agency and internalized structures.
4. Field topology. The broader field environment and the relationship of SAFs to other SAFs, particularly the State, are key elements in SAF theory. Change in SAFs may occur because of change in other, proximate or distal, fields.
5. Exogenous pressure. In SAF theory, exogenous shocks are important causal elements.
6. Institutionalization/De-institutionalization. SAF theory emphasizes contests and struggles over institutionalized rules. The onset of contentious episodes and episodes of contention themselves are important moments in SAF theory.
7. Field structure and settlement. What are the dominant frames in the field and who stands to benefit from them? In SAF theory, agency is always related to normative orientations to this question.

This body of work, which marks an important departure from Bourdieusian field theory (Bourdieu 1971), suggests that most collective action situations occur in strategic action fields as actors exert their agency using social skills in order to negotiate change in the field

itself. In this dissertation, the usability limits inherent in strategic action field (SAF) theory are tested, as it is suggested by its proponents that SAF theory suffers no loss from scalability. In other words, chaplaincies are sites of strategic action as much as hospitals, and State-religion relations are sites of strategic action as much as the health policy field. If this is true, then SAF is appropriate for the purposes of this dissertation, because it is argued that religious assistance in hospitals is the result of hospital-specific dynamics but is also embedded in religious field dynamics.

In order to further argue the line of thinking suggested in this dissertation, it follows that it is not enough to state that hospitals are strategic action fields. It is necessary to refine this assertion. Hospitals are specific organizations where some goal is pursued and religious assistance is a part of that pursuit. Henry Mintzberg's taxonomy of organizational dimensions and prime coordinating mechanisms is complementary to SAF theory because it allows for precise location and analysis of religious assistance services in strategic terms within a complex organizational environment (1979, 1983). It allows us to define hospitals as professional bureaucracies where biomedicine and medicalization are the core components of the symbolic power structure. Given that public hospitals in Portugal embody a specific secular construct, religious assistance services face complex challenges in traversing organizational boundaries. In following chapters, it is argued that the ability to traverse these organizational boundaries is constrained by other groups and the power structure within the hospital as much as the set of social skills employed by relevant individuals, namely Roman Catholic head chaplains. In addition, internal constraints exert additional influence over the strategic position of religious assistance services. Religious assistance services which are more integrated into the hospital are less likely to pursue strategies that rely on positioning themselves as outsiders in the hospital: they will be less likely to look for partners and support outside the hospital and will be less likely to reinforce links to organized religion. Conversely, weakly embedded services will pursue that very same strategy in order to ensure survival and some degree of legitimacy. The former case illustrates a higher institutionalization level, while the latter illustrates a lower institutionalization level. In both cases, agency is key: religious assistance services move according to strategic positioning as regards the hospital and the religious field. These services lie at the margins of both SAFs and it is here, in dual marginality, that religious assistance in hospitals becomes interesting as a research problem.

The modern hospital SAF is unlikely to accommodate religion because its organizational key component part, the operating core, is also the incumbent in the SAF. Incumbents are the

dominant actors in the field; generally, they are those who safeguard the dominant settlement because they perceive it as both beneficial to them and as beneficial to field stability. The biomedical settlement assigns dominance to incumbents as a set of institutionalized beliefs and practices that resonate and translate into broad social consensus. Religious assistance in hospitals is therefore highly dependent on institutional entrepreneurship and coalition-building. In SAF-theoretical terms, when religious assistance services are able to use their pooled social skill to achieve higher legitimacy, reputation and status, they are likely to be able to negotiate the biomedical settlement and seek better terms for the presence of religion in hospitals. But this requires coalition-building with sets of actors in the operating core of hospitals as well: biomedicine is dominant but is hardly conceivable as a totalitarian institution. Humanistic medicine and the promise of whole-person medical models, along with the growing recognition of healthcare services as providers of care in conjunction with disease-curing functions, opens organizational opportunity structures for action by religious assistance services.

3.2 Field theory

In John Levi Martin's words, "(…) field theory purports to explain changes in the states of some elements but involves no appeal to changes in states of other elements (…)" (2003, 6). According to this explication, "changes in state involve an interaction between the field and the existing states of the elements" (id, 6). These elements "(...) have particular attributes that make them susceptible to the field effect; the "force" that impinges upon some object in a field is a function both of the field effect, and of some characteristic of the object itself." (id, 7). As a conclusion, "the field without the elements is only a potential for the creation of force, without any existent force" (id, 7). Field theory is thus a relational approach to social phenomena; elements, be they individuals or collective, are members of a set and the field emerges by way of their relationships. Field theory ascribes fundamental relevance to the orientation of actors towards relationships. Where these relationships involve contests, over resources or frame dominance, they also involve strategy orientations. Initial theoretical remarks by Bourdieu suggest that fields are sites of power and struggle for hegemony; recent developments in field theory suggest that fields are not necessarily structured by power inequality or struggles for hegemony. Actors may be strategically oriented towards self-interested goals, but sense-making, the construction of shared meanings or the maintenance of the field itself are also important. As an example, religious fields may comprise actors interested in developing their positions in relation to others, but these actors are also interested in the salience of the field among the many fields that constitute society. Arguments about secularization or secularism

are important in the definition of strategic priorities by religious organizations and their preference for coalition-building with other religious organizations; moreover, religious organizations and their representatives may believe that the salience of religion is important enough to merit coalition-building despite unresolvable doctrinal differences, say between Protestants and Catholics. In field-theoretic terms, the dominant settlement over the religious field and the position of the religious field in relation to every other proximate field explains the orientations of actors inside it.

On this basis, Fligstein and McAdam provide an important sketch of what a unified field theory in social science might look like (2012: Chapter 1). SAF (strategic action field) theory, with extensions into the role of institutions and positionality, is one of the most interesting developments in meso-level sociological theory.

3.2.1 Fields and SAFs

Therefore, the primary theoretical proposition in field theory is the field. As mentioned by Martin, social scientific notions of the field are threefold. The first is topological: it pertains to pure positionality and unit membership into an identifiable set with identifiable boundaries. This was the initial insight of Lewin (1951). The second notion stems from classical electromagnetic field theory in physics and perceives the field as an organization of forces. The third, and most important as regards this study, is the notion of the field as a site of contestation (Martin 2003, 29). This notion is the starting point of Bourdieusian field analysis (1971, 2014). Modern sociological field theory may be understood from Bourdieu, even if the legacy of Lewin and Weber should be recognized as foundational. In providing microfoundational requirements for the emergence of fields, strategic action field (SAF) theory eschews the same structure-agency dichotomy field theory aims to deconstruct.

According to Fligstein and McAdam, a "strategic action field is a constructed mesolevel social order in which actors (who can be individual or collective) are attuned to and interact with one another on the basis of shared (which is not to say consensual) understandings about the purposes of the field, relationships to others in the field (including who has power and why), and the rules governing legitimate action in the field." (2012: 1). SAFs are, in this line of work, "the fundamental units of collective action in society" (id.) and are "focused on the emergence, stabilization/institutionalization, and transformation of socially constructed arenas in which embedded actors compete for material and status rewards" (id). SAFs are "recurrent games"

and the game metaphor, as deployed by Martin (2011) is especially useful in assessing the continuous aspects of strategy-making within a given field. The above definition may be split into three components: a theory of action ("actors are attuned and interact"; "relationships to others in the field"), a theory of institutions ("on the basis of shared (which is not to say consensual) understandings about the purposes of the field"; "the rules governing legitimate action in the field") and a theory of power ("(including who has power and why"). While absent from this definitional outset, nestedness and embeddedness are also important concepts in SAF theory.

When we apply the idea of a strategic action field to the current case study on hospitals we can develop a four-quadrant model of hospitals as organization. The insights provided by Mintzberg (1983) develop into a four-quadrant model of hospitals which, to our knowledge, is the most efficient conceptualization of hospitals-as-organizations available in the literature on management and organizations (Glouberman and Mintzberg 2001). Carapinheiro (1993) establishes clear differences in the distribution of power and knowledge in each hospital type (academic-general and general), following up on Chauvenet (1978).

SAFs may be discussed along three lines of inquiry:

1. **SAF identification**. At the micro-level, chaplaincies fulfill Fligstein and McAdam's requirements to establish field boundaries. These are SAFs within hospitals: religious diversity is an exogenous shock and responses to religious diversity are episodes of contention that produce instability in institutionalized meanings and procedures. There is a clear structure of incumbents versus challengers. At the meso-level, hospitals are SAFs for proximate reasons, but their location in the nested structure of broader SAFs induces different responses. An important insight derived from the chaplaincy-hospital nestedness is that hospitals tend to lock challenges related to religious diversity downstream. In other words, religion in public hospitals is less an issue of organizational performance than it is a local order problem: hospitals choose to decouple from their commitments towards the accommodation of difference by pressing the issue of religious diversity to existing structures, which are chaplaincies. At the macro-level, State-religion relations is an institutional arrangement best perceived as a field resulting from the complex relation between two fields: the religious and State fields in charge of managing religion. In this case, State agencies

form coalitions with the Roman Catholic Church in order to maintain historical settlements.

2. **SAF nestedness**. Chaplaincies are nested into hospitals. The organizational field of the hospital is nested into the State field but also into the religious field and the State-religion field. Nestedness is different from embeddedness: this is discussed below. In this study, fields are related by means of nesting; they are not parallel or related, but part of the Russian doll structure proposed by Fligstein and McAdam.
3. **SAF positionality.** Field position is not a matter of distribution into an incumbent/challenger dichotomy. A single collective actor may hold a position as an incumbent in a field and as a challenger in another. The same actor may change position along different analytical scales. Moreover, strategic orientations change for any given actor, regardless of its position as incumbent, challenger or internal governance unit, depending on the structure of the field itself and event sequencing.

Fligstein and McAdam propose a number of questions guiding field-theoretical research. I pursue three: Does the power structure of the field most closely resemble coalition or hierarchy? How strong is the consensus with respect to this settlement? How do external state and non-state fields help to stabilize and reproduce the field?

3.2.2 Actors and agency in field theory

Actors are field members that orient their strategies taking each other into account. Recognition is important to field theory: only those actors who are routinely taken into account when scripting action profiles and strategies are considered to be members of fields. Having something at stake does not translate directly into objective interest: it is primarily the perception of other actors that constructs field membership. Relationships are fundamental blocks of field-theoretic research; each actor and associated field position is what comes to constitute the field.

In SAF theory, actors are strategically oriented towards goals. They are not necessarily rational actors seeking utility maximization. The “existential function of the social” and “social skill” are the two factors one needs to take into consideration. The first pertains to the meaning- and sense-making functions of social interaction. The second pertains to the core skill actors need to employ when acting in and upon the field. If an actor is socially skilled, she may be able to convince other actors to legitimize rules, paving the way for institutionalization and settlement.

It is also the case that actors negotiate existing institutional logics. In democratic societies, "what tactics are possible, legitimate and interpretable" is a function of regulative and coercive institutions such as law (Alexander, 2006), but SAFs exist based on the normative force of institutions. For example, in the religious field two institutional arrangements provide the backdrop against which tactics are evaluated: legal requirements and doctrinaire legitimacy. These arrangements are not necessarily compatible and may eventually come to destabilize the field. This is so because actors need to make sense of themselves, others and the field more generally in a meaningful fashion. To do so, we need to remain attentive of "broad interpretive frame that individual and collective strategic actors bring to make sense of what others within the strategic action field are doing" (ib.). It is expected that "different interpretative frames reflecting the relative positions of actors within the strategic action field" emerge, because "actors will tend to see the moves of others from their own perspective in the field" (ib.). The question of positionality is central to SAFs: actors behave differently according to their relative and absolute position in the broader field.

3.2.3 Incumbents

In Fligstein and McAdam's words, "Incumbents are those actors who wield disproportionate influence within a field and whose interests and views tend to be heavily reflected in the dominant organization of the strategic action field" (ib.). Incumbents impose their dominance through tactics that are seen as legitimate by most other field members. Indeed, "field stability is generally achieved in one of two ways: through the imposition of hierarchical power by a single dominant group or the creation of some kind of political coalition based on the cooperation of a number of groups." Incumbents are likely to prefer stability, but this is not always the case. What is likely to be a regular pattern is incumbents' goal to maintain their position regardless of settlements or overall field stability. What matters is their position regarding others in the field.

Incumbents are identified in SAFs by their preeminence in rule definition and their "disproportionate" hold on resources, be they material or relational. Their field capital, so to speak, is necessarily higher than that of other actors in the field; their ability to deploy resources is likely very high; institutional arrangements are likely to overlap with core beliefs stated by incumbents.

Not every non-incumbent is a challenger in any given field, as that depends on strategic orientations and the availability of frames that recognize challenging as legitimate. This

discussion will merit more reflection in the concluding chapters. In SAF theory, challengers "occupy less privileged niches within the field and ordinarily wield little influence over its operation. While they recognize the nature of the field and the dominant logic of incumbent actors, they can usually articulate an alternative vision of the field and their position in it" (ib.). Field membership is a requirement for challenger status, as is lack of resources and the recognition of a dominant logic by an identifiable set of field members, which are seen by challengers as incumbents. Incumbency is then assigned not only by the field but also by challengers, who juxtapose dominant institutional logics to what they believe are other actors' understandings. What gives challengers their label is their ability to construct alternative orders and field settlements, not their will and capability to challenge those orders and settlements. Indeed, being a challenger in a SAF does not "mean that challengers are normally in open revolt against the inequities of the field or aggressive purveyors of oppositional logics. On the contrary, most of the time challengers can be expected to conform to the prevailing order, although they often do so grudgingly, taking what the system gives them and awaiting new opportunities to challenge the structure and logic of the system" (ib.). From this, we can derive the following: challengers are always on the lookout for breakout opportunities, either with the purpose of amassing resources or with the purpose of openly questioning the dominant logic of the field and by extension the privilege of incumbents. SAF theory falls short of offering a full account of challenger types. The structure of the field, whether coalition- or hierarchy-based, is the main explanatory factor in establishing challenging status. However, in different contexts or during different field events, actors may be perceived as both incumbents and challengers by any number of actors within the field or within proximate fields.

One of SAF theory's main innovations is the postulation of internal governance units. Traditional social movement research describes struggles and mobilization as a dyadic relationship: incumbent-challenger. Fligstein and McAdam suggest that "many strategic action fields have internal governance units that are charged with overseeing compliance with field rules and, in general, facilitating the overall smooth functioning and reproduction of the system. It is important to note that these units are internal to the field and distinct from external state structures that hold jurisdiction over all, or some aspect of, the strategic action field" (ib.). A complex extension to field theory, Internal Governance Units (IGU) are tasked with stabilization and compliance; these actors are regulatory agencies with strategic orientations towards power asymmetry; in Fligstein and McAdam's words, "virtually all such governance units bear the imprint of the influence of the most powerful incumbents in the field and the

ideas that are used to justify their dominance. Regardless of the legitimating rhetoric that motivates the creation of such units, the units are generally there not to serve as neutral arbiters of conflicts between incumbents and challengers but to reinforce the dominant perspective and guard the interests of the incumbents" (ib.).

3.2.4 Institutionalization and power structure

Field emergence is a key instance for SAF theory. However, some SAFs in modern societies are past their emergent states and are now institutionalized and their role structures (the dyad incumbent-Internal Governance Unit/challenger) are stable. One of the foundational questions in field theory, from Bourdieu to Clegg or Fligstein and McAdam, is the power structure in stable fields. Among other factors, "group size, access to government, existing law, knowledge of various organizing technologies, and other external allies all play a role in who in a given strategic action field might be able to gather the resources either to form a political coalition or dominate the field" (Fligstein and McAdam 2012: loc3836). Fields become institutionalized as boundaries become established and actors inter-subjectively recognize their membership in a field. No field is perfectly horizontal or vertical. SAF theory describes two ideal-typical power structures: hierarchy and coalition. Both are stability-inducing: "Field stability is generally achieved in one of two ways: through the imposition of hierarchical power by a single dominant group or the creation of some kind of political coalition based on the cooperation of a number of groups" (Fligstein and McAdam 2012). Furthermore, hierarchies and coalitions need not be clear cut: hierarchies may be based on coalition-seeking strategies by incumbents which convince less powerful actors (with challenger strategic orientations or without them; preferably without), turning the structure into a hybrid. Situational profiles include three elements – rules, resources and social skills. The interplay between these two profiles describes the power distribution patterns in SAFs. It is also in this interplay that the key role of the State in stable fields comes to the fore.

The role and performance of State fields and actors is very important to SAF theory. In describing the State as its own set of fields, SAF theory assumes limited State autonomy (Evans 1981): "State actors have their own interests, identities, and institutional missions, which routinely affect non-state fields. But, of course, the process can work in exactly the opposite fashion: important groups or organizations in established (or emerging) fields can take their grievances to the state and attempt to control the agenda that will regulate relations in their fields." (Fligstein and McAdam 2012: loc3855). But the reverse, that of State dominance, may

apply. Attempts to control regulatory agendas in monopolistic religious fields are frequent, as the Portuguese case shows. The most important insight of SAF theory in this regard is twofold: the role of the State in a given field and the relationship between specific fields and State fields. According to SAF theory, one "can tell how the balance of power is set up in a strategic action field only by explicitly considering the role of the state in that field. This is one of the fundamental mistakes of organizational theory and sometimes social movement theory; that is, they use the state in an ad hoc fashion and invoke it either as the enemy or as an actor that might occasionally muck things up. However, it is impossible to evaluate any form of strategic action in a field without considering the history of state intervention in that particular arena" (Fligstein and McAdam 2012: loc:3873). States are not fully independent from SAFs; as collective actors, they have vested interests in specific fields. SAF theory scales up and down easily in this regard, as it postulates simple, but powerful explanatory relational patterns that translate from actor-to-actor relationships to field-to-field relationships. This is the case of State and so-called "non-state" fields. "There is likely to be feedback between state and non-state fields. As situations change on either side, this feedback will have consequences for the boundaries and nature of strategic action fields both in and outside of the government. The result is an iterative stimulus–response "dance" involving state and non-state actors" (Fligstein and McAdam 2012). The literature on State-religion relations overemphasizes stability and the logics of incumbency. While States seek to manage the religious field, State action may have unintended or unpredictable results: "the relationship between what goes on in the strategic action fields of the state and the rest of society can also have unintended consequences. The passage of a law may affect a large number of strategic action fields in intended and unintended ways. Many studies of strategic action fields begin by looking at these kinds of consequences" (ib.). State fields need to be disaggregated, as they are "dense collections of fields whose relations can be described as either distant or proximate and, if proximate, can be characterized as existing in either a horizontal or vertical relationship to one another" (ib: loc538). This is the case as regards the Portuguese religious field. After remaining stable for several centuries, it became destabilized because of crisis episodes in the State field, which came to threaten the hierarchical character of the religious field itself. Furthermore, seeing States as collections of fields allows us to discuss why, at a specific juncture, religious field settlements came into conflict with the healthcare State field. Different strategic orientation among State actors, which are weakly bound to non-state fields, explains field power structures to some extent. Modern polities assign unique power and resources to States for the management of power distribution in fields. In democratic polities, this assignment theoretically intends to prevent

monopoly situations and to increase pluralism, but this is hardly the case across most fields. States are strategically oriented towards the maintenance or creation of plural politics. The problem of institutionalization and power asymmetry is fundamental.

It is important to emphasize that hierarchy and coalition are dynamic states: as actors seek to change their status and position, they seek new strategic orientations and ways to frame the field, their field partners/opponents and existing rules, which entails change in the field itself. In this sense, fields are configurational and stochastic; structural accounts of field theory tend to underplay the ability of actors to change field components. If an actor is sufficiently skilled in reframing a rule and moves hierarchy into an open contest over dominance, all other actors will reposition in order to face a new order, produce new meanings and refashion relationships. While the institutional pillars of SAFs are stable and taken for granted, as sociological institutionalism suggests, the strategic orientation of actors undercuts equilibrium or long-running stability. IGUs are important additions to field theory because they illustrate the nestedness and embeddedness of fields, as well as latent struggles; the presence of IGUs in a SAF promotes stability. Since IGUs are not as sensitive to positionality as other actors – these units get their resources from outside the field and, while reinforcing incumbent dominance, are not as invested in enforcing stability as incumbents or in promoting alternative settlements as challengers. Incumbents are necessarily more sensitive to these problems because their stakes are bounded to the field itself. The problem of settlement, rupture, crisis and resettlement then becomes a focal point for SAFs and SAF theory. In this dissertation, the 2009 Regulation on Spiritual and Religious Care in Hospitals is a clear example of a resettlement after a moment of crisis. Existing religious assistance services reacted in different ways to the critical juncture and reconfiguration of the SAF; challengers in the religious and healthcare policy fields sought to disrupt the dominant settlement and deploy a settlement which would be more favorable to their interests: in the case of challengers within the religious field, a settlement which would displace Roman Catholics from positions of power; in the case of challengers within the healthcare policy field, a settlement which would displace religion from hospitals.

3.2.5 Settlement, rupture, crisis and resettlement

The problem of episodic contention is crucial to SAF theory and, particularly, to stable fields. In this dissertation, the Portuguese religious field is an important example. It remained a stable field with little contestation over dominant settlements and roles until the entering into force of the 2001 Law on Religious Freedom, which forced a redefinition – and then resettlement –

of the dominant settlement, incumbents, challengers and the position of the internal governance unit. The 2001-2009 period was characterized by its dynamism and uncertainty in this field had important consequences to the religious assistance in hospitals issue of the healthcare policy field. This is why an analysis of religious assistance in Portuguese hospitals conveys relevant information about proximate/distant field relationships and the emergence of contention in apparently settled fields. At any point before 2009, few actors in either field (religious or healthcare policy) would have foreseen conflict over the dominant settlement and the exceptionality accorded to the Roman Catholic Church. In fields such as those discussed in this dissertation, available tactics for questioning the prevailing settlement are fewer, challengers have less access to resources and are generally less able to discover and structure alternative field orders that may drive their strategic orientations. To sum this up, the prevailing settlement is the shared compound assumption of what a field is, which actors are field members, what are the field's institutional pillars and what are legitimate tactics for contestation. Conflicts over this basic component of settlements suggest imminent rupture and the onset of contention. Settlements are always shared but rarely consensual; when those less favored by the power structure amass resources, reframe the field or use their social skill to build a coalition, the shared-but-not-consensual character of the basic institution in fields becomes conflictive. Redefinition of fields allows actors to include or exclude other actors, which is a basic strategy in stable fields.

For the purposes of this study, settlements are shared rules about legitimacy which define the position of each actor in the field. This applies to any given scale. Chaplaincies, hospitals and State-religion relations are nested SAFs; if we start at the meso-level of hospitals and religious organizations looking for the role of legitimacy, we see that resource flows are dependent on legitimacy, reputation and status. Resource flows are dependent on legitimacy – which will change depending on the type of settlement that comes to be shared by field members. More legitimate members will garner more resources and will in principle perform the role of incumbents. The same applies to challengers, which have more fluid action profiles; in principle, stable SAFs do not have illegitimate incumbents, but they may have legitimate challengers. If State fields are strategically oriented towards religious pluralism, for instance, they may enforce rules that define which groups are legitimate even though incumbents in the field do not see them as legitimate, high-status or reputable.

In fields where hierarchies are stable but contentious episodes increase in frequency, this relationship comes to be important: those challengers to existing settlements who are seen as

legitimate, reputable and hold high status in the field are more likely to attain their strategic goals.

The understanding of settlements as rules in the making shows the potential for rupture, both by incumbents, who might see the benefit of correcting field trajectories and dominant frames, and challengers, who might see the advantage of rupturing existing settlements, forcing the field into crisis. Often, these episodes lead into the retrenchment of incumbents and increased dominance. This why most revolutions fail and why most religious fields are locked into path-dependent trajectories. But there are moments where the infrastructure of legitimacy in a given field comes undone. The opportunity structure for contentious actors opens and, depending on their previously amassed resources and ability to frame the contest in a way that allows them to build coalitions, sometimes with dissatisfied incumbents.

3.2.6 Field nestedness and embeddedness

Field nestedness and embeddedness are two core concepts in SAF theory. The first pertains to the fact that most SAFs are nested. Hospital chaplaincies are nested into hospitals, which are in turn nested into healthcare. These relationships are not linear. Hospital chaplaincies are also nested into the religious field and hospitals are nested directly into the State field, because of their status as public institutions. Nestedness means that smaller fields are likely to be contained in larger ones. Fligstein and McAdam present two distinctive features of SAF relationships: they are either distant or proximate and either dependent or interdependent. These distinctions allow us to discuss a key difference between nestedness and embeddedness.

The most important distinction in SAF theory is that of field dependence and interdependence. In Fligstein and McAdam's words, a "field that is largely subject to the influence of another is said to be dependent on it. This dependence can stem from a variety of sources, including formal legal or bureaucratic authority, resource dependence, or physical/military force. Formal bureaucratic hierarchies of the Russian doll variety embody the first of these sources of dependence" (2012: loc531). Non-state fields in Western European polities are likely to be dependent on State fields for their functioning; IGUs sponsored by States are likely to be present in most non-state fields. Seen as open systems, "all lower level fields are nested in, and formally dependent upon, all higher level systems" (ib: ibid.). In the event that two proximate or linked fields exercise equal and reciprocal influence over each other, they are said to be locked into interdependence. Therefore, fields are nested when they are integrated into vertical orders and when other, larger-scale fields exert non-reciprocal influence over them. This is the case with the SAF structure this study aims to discuss: hospital chaplaincies are unlikely to

exert non-reciprocal influence over the organization of State fields. They are nested into a complex structure.

Nested fields do not necessarily need to be embedded. Embeddedness relates to the strength of ties linking fields: fields are highly embedded when they are highly dependent on other fields. Thus, hospital chaplaincies are embedded in hospitals because, without support of the organizational field of the hospital, a hospital chaplaincy would not exist. Hospitals are not highly embedded in the healthcare State field because they are complex fields which are somewhat influenced by the larger field but are able to function in a semi-autonomous As we move farther down the nested structure of SAFs, the more likely it is that we find highly dependent fields with very levels of embeddedness. Actors at these levels will likely need to comply with different sets of institutions and settlements and with different fields, sometimes within the same interaction situation.

3.2.7 Conclusion

Field theory provides a unified theory of social action. SAF theory is a promising, if incomplete, version of field theory which offers several useful extensions: it underlines strategic action and actor-driven field dynamics, inserts cognitive and cultural factors, discusses internal governance units and assesses the meta-structure of fields. Organizations and organizational subsystems are profitably seen through the lens of field theory. Public hospitals and hospital chaplaincies, or religious assistance services, are two examples. As mentioned above, given appropriate specifications, most social instances may be defined as strategic actions fields. In this dissertation, State-religion relations, public hospitals and religious assistance services are strategic action fields. In the case of religious assistance services, this is not always the case, as there may be no more than a single actor and as such no positional structure from which to posit the existence of a field. Public hospitals may be theorized as strategic action fields; for optimal theoretical leverage, we need to discuss issues of organizational theory in order to ascertain whether SAF theory is advantageous in relation to other approaches. The same goes for hospital chaplaincies: their status as SAFs is postulated in this dissertation, but SAF theory needs to be extended in order to fully accommodate this assertion. Field-theoretic research is flexible in this regard, as it allows for iterative, quasi-Bayesian reconsideration of theory against empirical findings. In the next chapter section, I discuss hospitals as SAFs *and* organizations. I utilize the Mintzberg-Glouberman four worlds model of hospitals and discuss how it may be modified in order to accommodate European hospital settings.

3.3 The hospital as an organization

Hospitals are complex organizations. They are arguably the most complex modern organizational forms in the strategic action field of healthcare. Foucault (1963), Risse (1999), Wear (2003) and Granshaw (2000, 1989) discuss the emergence of hospitals as providers of modern medicine. Freidson (1970c) provides one of the earliest sociological studies of hospitals, while Chauvenet (1978) and Carapinheiro (1993) discuss medical power and knowledge in the modern hospital.

Henry Mintzberg (1983, 1979) is the most important discussant of the modern organizational form taken by hospitals. Mintzberg's perspective lies at the intersection of two schools of thought in organizational studies. Mintzberg's analysis approaches organizations as sites of power; in that sense, it sits squarely in the power perspective proposed by Clegg (1990, 2006, 2010). In this perspective, power is the core factor driving organizational life. The power perspective is, in Clegg's analysis, a form of contingency theory where organizations and their respective environments should "be conceived as arenas where actors with different power levels, that is to say with differential control over available resources, compete for differently-valued resources in the context of complex games and rules by indeterminate rules which each actors seeks to exploit for its benefit" (Clegg 1990: 96).

An important research tradition explores DiMaggio and Powell's "iron cage" perspective, based on Selznick (1957) and Perrow (1986). This perspective holds that organizations develop in cultural contexts from where they gather examples and frameworks: the most important contribution of this research program was the notion of "institutional isomorphism". Organizations tend to isomorphism on the basis of pressure mechanisms, which may be mimetic, coercive or normative.

A second influential tradition stems from Zucker (1988) and Meyer and Rowan (1977). A more agentic approach, this institutional perspective emphasizes embedded meanings in organizations and framing processes. Zucker's work is particularly focused on the cognitive aspects of organizational processes: actors pick up on existing knowledge repertoires and work with them in order to frame their positions and significance in an organization. Religious representatives in hospitals need to face the double frame of medicalized knowledge and organizational publicness; in order to harness resources, these representatives and their institutionalized settings, which take the form of chaplaincies in hospitals, need to present themselves to internal and external audiences as legitimate, i.e. holding high status and high

reputation. As argued in the following section, these strategic constraints occur within a specific organizational form, that of the professional bureaucracy.

3.3.1 Three basic organizational dimensions

The Mintzberg taxonomy starts by stating that all organizations are different along three dimensions. The key part of an organization is the organizational core strategic component: organizations differ from each other at a fundamental level based on where their decision-making power lies. The prime coordinating mechanism is the basic method of decision-making and structured coordination used in the organization to make it coalesce into some level of strategic consensus. The type of decentralization is the degree to which power distribution is evened out by the involvement of non-key parts in organizational decision-making.

3.3.2 Prime coordinating mechanisms

In this approach, five prime coordinating mechanisms are fundamental to organizational flows. These are identifiable in hospitals. As shown in Chapter 6 and 7, these coordinating mechanisms constrain the ability of chaplains and religious representatives to traverse the internal boundaries of the hospital where they strategize towards goals.

1. Direct supervision entails the deferment of responsibility to another structure, usually an upper organizational layer. Instructions are issued based on this vertical structure and its supervisor monitors each key organizational component.
2. Standardization of work process entails the specification and programming of organizational work contents.
3. Standardization of output entails the standardization of organizational production outputs.
4. Standardization of skills entail the specification of qualifications required to perform in and belong to the organization.
5. Mutual adjustment entails the coordination of organizational flows and work through informal communication.

Each of these five coordinating mechanisms may be illustrated with recourse to empirical data gathered for this dissertation. There is no direct supervision of religious assistance by hospital administrations in any of the three cases analyzed for this dissertation. Instead, each hospital shows different levels of engagement with religious assistance along a continuum which is

usefully described as direct neutrality. Religious assistance does not defer responsibility on a voluntary basis to hospital administrations; this is particularly visible in the case of Hospital A. This is why, as discussed in Chapter 7, all dimensions of religious assistance in Hospital A are oriented towards survival and an outward strategy. The structure of hospital A is conducive to such orientations because it is more centralized than in either hospital B or C.

Standardization of work processes, output and skills is identifiable in Hospital C. This is why, as described in Chapter 6, religious assistance is oriented inwards: there is no incentive to seek survival because survival is assured. Instead, religious assistance in Hospital C strives for attaining the status of fully-accredited support service and has sought advice from a Catholic-run health facility where spiritual care impact is measured according to peer-reviewed scales. This strategic priority is built on the conducive environment of Hospital C, where humanization of hospital premises, medical practice and staff demeanor is institutionalized and spoken of as a differentiating factor from other high-end hospitals.

Mutual adjustment signals an environment where informal communication and the establishment of informal bridges among organizational quadrants is the most important information relaying system. This is the case of Hospital B. Religious assistance operates within the constraints of this coordinating mechanism by maintaining an average level of integration into the hospital and thus supporting its activities through informal activity. It relies, more than in the two other cases, on the skills of a specific individual who, as shown in Chapter 6, opted out of both standardization and stagnation. This is exemplified by the multi-faith roster now operated by the Hospital B religious assistance service.

Each of these prime coordinating mechanisms are connected to four types of decentralization.

Centralization and decentralization are the core dimensions of power distribution in any organizational structure. A structure is centralized when all decision-making power "rests at a single point in the organization" (ib.:95); it is decentralized when decision-making power is dispersed. In modern organizations, with the exception of very simple ones, power is necessarily dispersed and thus decentralized to some extent. From this simple statement, four types of decentralization occur.

1. Vertical decentralization pertains to the dispersal of formal power downstream in the organizational structure.
2. Horizontal decentralization pertains to the extent to which non-managers control decision making.

3. Selective decentralization pertains to the notion that decision-making power over different issues is located in different organizational components.
4. Parallel decentralization pertains to the dispersal of decision-making power over different issues to the same organizational component.

3.3.3 Five key organizational components and a basic structure

The basis of Mintzberg's taxonomy is a synthesis of the relationships between each component part.

According to Mintzberg, "the strategic apex is charged with ensuring that the organization serve its mission in an effective way, and also that it serve the needs of those who control or otherwise have power over the organization (such as its owners, government agencies, unions of the employees, pressure groups)" (1992: 13). The strategic apex shoulders three basic duties. First, it directs supervision. Second, it manages the organization's relations with the field. Third, it develops the organization's strategy. Because of these duties, "the strategic apex takes the widest, and as a result the most abstract, perspective of the organization. Work at this level is generally characterized by a minimum of repetition and standardization, considerable discretion, and relatively long decision-making cycles. Mutual adjustment is the favored mechanism for coordination among the managers of the strategic apex itself" (id.:14).

The middle line is the interface between the strategic apex and the operating core. It is composed of actors hold mid-level authority who are seen as legitimate by both the strategic apex and the operating core. Since "the organization needs this whole chain of middle-line managers to the extent that it is large and reliant on direct supervision for coordination" (ib.:15), the middle line maintains the flow of core organizational processes; it is endowed with middle-level legitimacy which allows middle line actors to engage with all levels of organization.

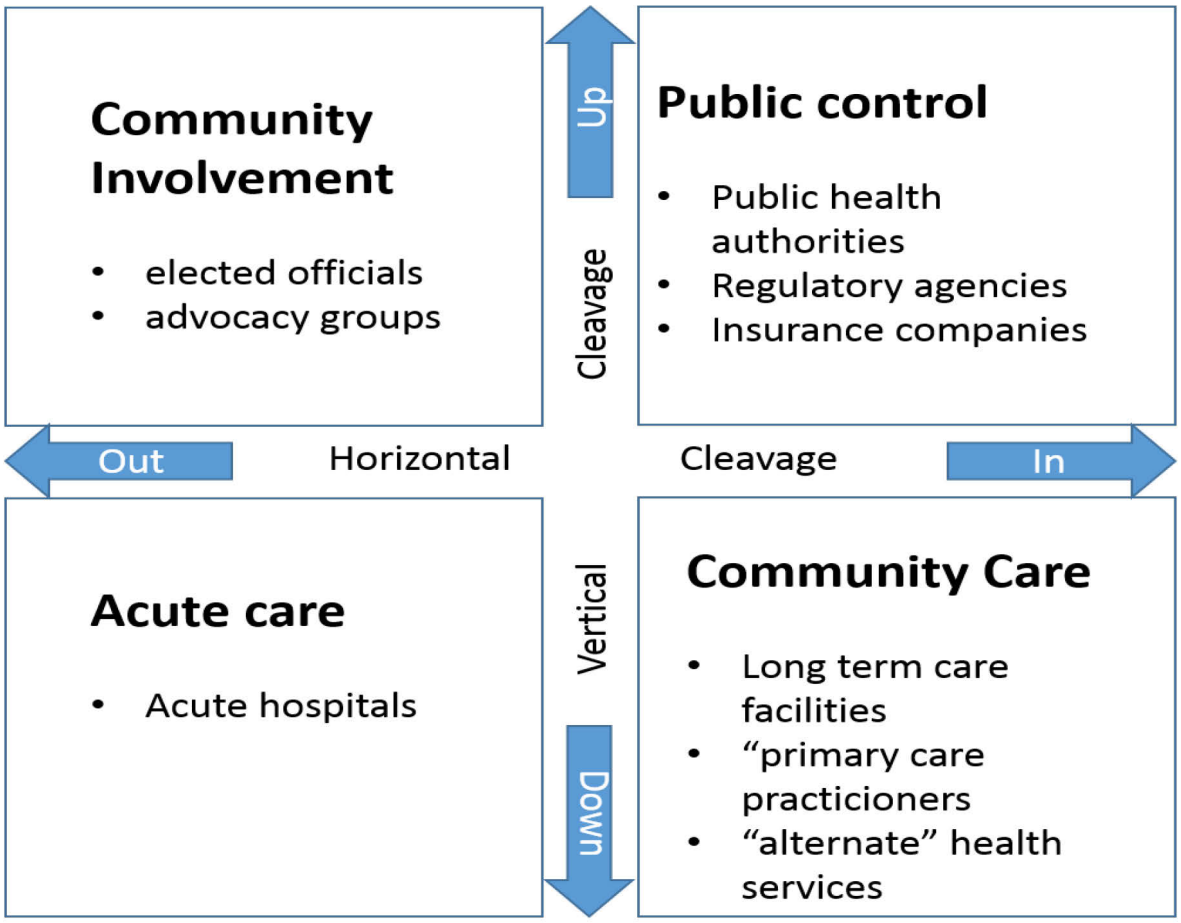
The operating core "encompasses those members—the operators—who perform the basic work related directly to the production of products and services" (ib.: 12). It has four basic functions: it gathers and secures inputs for the production of whatever the organization is structured to produce. In the case of hospital, the organization is structured to produce health. Its operators are responsible for the output; it distributes the output; it provides direct support for the production function of the organization. The operating core is the most basic component of any organization; while its basic functions as per Mintzberg are disputable, the power function of the operating core is the most important feature in the categorization of organizations.

The technostructure is best identified through the identification of its component actors: "Who makes up the technostructure? There are the analysts concerned with adaptation, with changing

the organization to meet environmental change, and those concerned with control, with stabilizing and standardizing patterns of activity in the organization." (ib.: 15). The technostructure maintains and enforces standards within the organization, largely contributing to the strategic performance standards set by the strategic apex, without participating in the organization flow itself.

Supporting units do not provide direct support; they provide indirect support to the operating core. While Mintzberg ascribes important functions to supporting units, institutional insights seem to be useful in determining why support units and staff exist in an organization, as it would likely improve efficiency to outsource most support functions. As we will see, chaplaincies and religious assistance generally falls into this category.

Figure 1. The hospital organizational field



These five components lead to an important taxonomy, arguably the most influential in the study of hospital organization. Figure 5 illustrates each ideal-type. For the purposes of this dissertation, professional bureaucracy is the most important class in this typology.

The professional bureaucracy is based on standardization of skills. Its key component part is the operating core. Vertical and horizontal decentralization occurs widely, as professional

power requires autonomy and professional tend to frame their work as organizational monopoly. Professionals in this organizational form tend to be highly trained and need to seek restrictive certification from external actors, usually State actors. As a result, the technostructure and strategic apex are small (but never non-existent, as professional bureaucracies need formal structures), but support staff and units are sizable.

3.3.4 The hospital as a professional bureaucracy

Correia suggests that the hospital is a prime example of a professional bureaucracy (2012: 110). The author focuses on the bureaucratic functions of hospitals: as healthcare organizations, hospitals seek standardization of output without loss of information. Since the cure function lies at the core of hospital output, standardization of output requires standardization of skills. Professional bureaucracies exist where professionals hold the power to shape organizations: hospitals are medical worlds, as it were, because the cure function dominates any outputs of key parts. Contrarily to other modern organizations, hospitals have resisted their transformation into divisionalized forms partially because medical power rests on a paradox: it seeks unity in medicalizing everyday life, a process from which it enhances its legitimacy, status and reputation, but its core is driven by conflict between different medical experts, particularly surgeons and internists. This paradox explains why hospitals may look like divisionalized forms: many hospital wards have their own technostructure and particularly their own support staff. Some will resemble adhocracies, as some hospital functions require decentralization and case-based decision-making. Surgery is an important example of this: as surgery is likely to require costly technological investment and protracted training, it weighs heavily on the operation of hospitals. Surgery is also heavily involved in medicalization and the escalation of medical rationalities, as explained by Conrad (1992, 2008) and Good (2008, 2010) and developed elsewhere by . Professionalism is widely documented as ideology and practice (Freidson (2001, 1970a, b, Larson (1977)). Medical professionalism is an important theme in research on professional ideologies.

Correia (2012) argues that changes in management and power structures in Portuguese modern public hospitals could entail a shift from professional bureaucracy to divisionalized form. As any judgment call, it is an important contribution. At this point, the theoretical framework presented here maintains that Portuguese public hospitals are generally professional bureaucracies where medical professionalism weighs heavily as ideology. But what does the performative role of religion and religious assistance tell us about these forms? Where do

religious assistance services position themselves within these physician-dominated organizations? These questions re-introduce the question of making Mintzberg's taxonomy compatible with SAF theory, before tackling the four-quadrant model of hospital organization.

3.3.5 The Glouberman-Mintzberg model of hospital organization

The literature on the organizational design of hospitals is not as large as other aspects of hospital life. While studies of hospital typologies exist, along with the power structure of professional bureaucracies, systematic efforts towards a theoretical model of hospital organization are few. The Glouberman-Mintzberg model is arguably the most successful one for two reasons: first, it simplifies the organizational configuration of hospitals into manageable analytic components; second, it is easy to modify. Figure 6 shows the basic features of the Glouberman-Mintzberg model. It comprises four quadrants and two axes. The model is based on management processes, according to the authors, as "management here [in the hospital] is not one homogeneous process but several" and they are "usually quite distinct from one another" (Glouberman and Mintzberg, 2001: 59). This focus on management is problematic as it lacks consistency with the previously argued categorization of hospitals as professional bureaucracies. This may be a consequence of the model focus on American contexts; however, drilling down on the specifications shows how powerful it is. Because it strips hospitals of their complexities, this model achieves the important goal of being generalizable and adaptable to local orders: all hospitals will show evidence of the existence of a four-quadrant, dual-axis structure, but each hospital will likely function differently by putting different emphases on quadrants and axes. Moreover, organizational actors may traverse quadrants depending on interaction situations, may hold positions in more than one quadrant or may hold a position related to more than one quadrant. The four quadrants are, clockwise, control, care, cure and community. In order to connect this model to Mintzberg's taxonomy and SAF theory, they are discussed in the following order: 1) control, 2) cure, 3) care and 4) community.

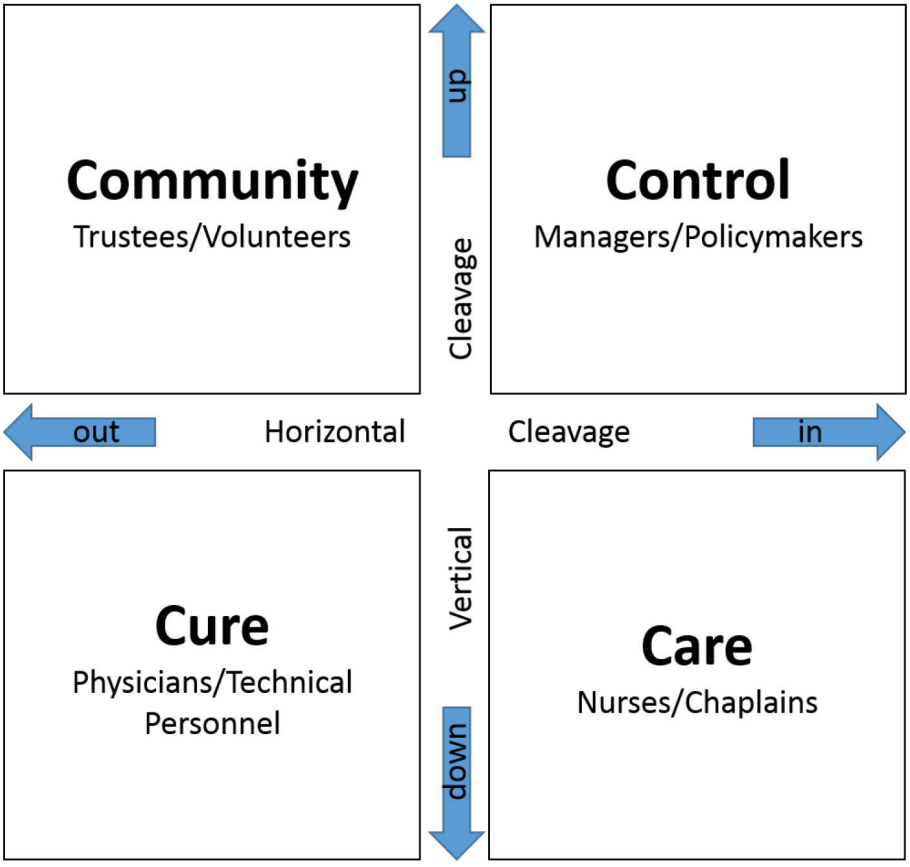
The control quadrant comprises all command functions, both directly and indirectly related to organizational functioning. Following Mintzberg's taxonomy, this would be the strategic apex. Hospital administration structures are located in this quadrant. In the Portuguese context, this would comprise hospital administration boards. However, support staff or units related to administration are also located here. Policymakers are also part of the control quadrant in hospitals, especially public ones. These actors, who are not strictly within organizational

boundaries, may appoint hospital managers and politicize hospital administration. This is the key relationship as regards the location of hospitals in the State field and the strongest argument for establishing that public hospitals are strategic action fields nested in the State field, where medicalization and publicness are institutionalized but power-distributional issues throw the professional bureaucracy into rupture.

The cure quadrant comprises the medical community and its supporting structures, which comprise part of the support staff and part of the technostructure. This is the operating core of a public hospital. It is important to underline that part of the strategic apex also lies within this quadrant. Hospitals as organizations are principally geared towards the provision of health, which, because hospitals operate within a biomedical settlement, translates into curing disease. This in turn empowers the operating core and confirms that hospitals are professional bureaucracies; in other words, hospitals without doctors and nurses would not be hospitals. Medical actors in hospitals are effectively incumbents, as they shape the organizational field settlement and hold the power to steer the organization. They have their own strategic apex in their managing committees: in the Portuguese context, all public hospitals have medical and

Figure 2. The Four Worlds of Hospitals

nursing directors. Office-holders must always be physicians and nurses. In this quadrant, support staff and technostructure report back to these directors and they make up the operating



core of the organization; while the shift towards managerialized governance entails the transfer of power to the control quadrant, physicians and nurses are still beholden to the cure quadrant and its institutions. The dominant settlement in public hospitals favors this quadrant and it is within its boundaries that power over the overall functioning of the organization is to be found. Physicians in public hospitals maintain a close but hierarchical relationship with nurses and care personnel. The care quadrant is a strikingly important context to this study because it is the most bounded quadrant in the model – since nurses report both to physicians and the administration – but also the most likely to challenge medical power and the monopoly of physicians over knowledge. The care quadrant is the most integrated of all four quadrants and it connects on a more fundamental level to the organization as a whole: its integration and integrative function weakens its power, but strengthens its influence. It makes theoretical sense to include religious assistance in the care quadrant. Religious assistance is a form of care. The question here is: to what extent do chaplains in public hospitals see themselves as members of the organization and members of the care quadrant? As mentioned before, religious assistance is not very integrated into the organization because medicalization and publicness prevent such integration, but we start to see other reasons: the cure quadrant, which comprises the operating core of hospitals, sits on a settlement that depends on the shared premise of biomedicine. Religious assistance is logically excluded and has no place in such a field. But it is actually present in every public hospital in Portugal, for example. As a type of care, it challenges the monopoly of organizational knowledge because physicians are neither trained, willing nor able to provide religious assistance. Religious assistance providers, to the extent that religious assistance is traditionally a community function, report to different organizations and frame their positions based on two different institutional packages. Boundary conditions can never apply fully to chaplains in public hospitals, even when they are paid staff members; they are external consultants, as it were. Turning to the care quadrant, we see how this may play out.

The care quadrant comprises all medical staff that is not immediately concerned with cure. This means that nursing personnel along with therapists who do not qualify as physicians but do provide care certified by the organization make up a different organizational world within the hospital. Because these actors are seen as support staff by the wider organization, it would be inconsistent to theorize a structure comprising an operating core, a limited support staff, a very limited technostructure and a strategic apex. Generally, these actors are not incumbents: they have grievances of their own and they seek autonomy from the undisputed power exerted by physicians. However, they are not necessarily challengers to the existing settlement. Nurses are

unlikely to dispute biomedicine overtly; instead, because their position in the organization entails close contact with patients and other therapists, they tend to support alternative modes of operating and interacting in hospitals. We see this by looking at humanization procedures in these organizational settings: nurses are likely to lead these efforts, because their work shifts mandate close contact with suffering. Furthermore, the care quadrant is more plural than the cure quadrant and not as hierarchical. Internal power distribution is more equal; it is highly unlikely that nursing staff at any given hospital is split into skill-based groups as seen in the hierarchy established between surgeons, specialists and internists in the cure quadrant.

In its modern form, religious assistance in Portuguese hospitals is better termed SRA – Spiritual and Religious Assistance, but it could well be termed spiritual and religious care. Chaplains and other religious representatives operate in close connection with nursing staff and represent their tasks and operations as care. Chaplains and some religious representatives are seen by hospital administrations as providing some sort of care. Physicians do not necessarily share this view (Queiroga 2013). This is a result of low integration and the peculiar boundary-crossing religious assistance needs to operate in order to exist as care. Since religious assistance operates in two SAFs, the religious and the public healthcare field (a nested State field), to some extent it is marginal to both: while this is trivial as regards the public healthcare field, it is hardly so as regards the religious field. Chaplains survive and develop their work at the margins of the religious field, as suggested by Norwood (2006). But, as we will discuss in following chapters, it is precisely the precarious position of religious assistance that lends it some structural fluidity and makes it dependent on agentic factors, namely institutional entrepreneurship. In order to become a fully integrated care quadrant member, the chaplaincy in a public hospital is required to use its pooled social skill in order to convince other actors in the hospital, particularly in the care quadrant, that religious assistance is a type of care and that it poses no challenge to the biomedical settlement. The degree of success in coalition-building and frame reconfiguration is largely determined by the quality of institutional entrepreneurship. These processes operate within the care quadrant. But hospital chaplaincies are only as legitimate as they are able to connect with the community quadrant.

In Southern Europe, public hospitals do not generally hold trustees; they are public enterprises or public bodies and their recent transition into managerialized operations did not translate into the inception of forms of non-profit governance, such as the implementation of boards of

trustees nominated among high-status individuals. So we need to look elsewhere in order to identify community quadrant components.

If we look at the Mintzberg taxonomy again, we are able to discern potential community quadrant members. These are support staff that are not necessarily paid members; they do not need their skills to be certified. Volunteering actors and associations are increasingly important in the process and production of hospitals: Portuguese public hospitals veer towards substitution of nonessential functions by volunteers. But the community quadrant comprises more than the set of volunteers operating in a hospital. It comprises any stakeholder that, while not fulfilling boundary conditions to be thought of as part of the organization and not being part of the output function at any stage, is nevertheless a stakeholder. This expansive definition comprises inbound and outbound patients, bedridden and ambulatory patients, former and potential patients and those collective actors which seek to attain medicine-related goals, such as patient rights associations. Patients, in conclusion, are the other components of the community quadrant.

What is the role of religious assistance in the community quadrant? This is an important question. We have suggested that religious assistance should be positioned within the care quadrant. But religious assistance, because it relates specifically to a field that exists outside hospital boundaries, may be said to be part of the community quadrant: many volunteers see their work as driven by religious belief and most – if not all – chaplaincies are supported by volunteers. Pastoral work in healthcare settings is now discussed in Catholic venues as being open to leadership by lay personnel. In this sense, religious assistance is a form of self-organization by community within hospitals. Thus, religious assistance does not only operate both within and without the boundaries of the hospital; it also operates across the care and community quadrants.

Let us now discuss the two axes in this model: in-out and up-down. The former pertains to the established boundary conditions: a quadrant operates inwards when it seeks to manage or influence other actors within established boundaries and outwards when it is not pegged to the inner workings of an organization and is seen as involved in organizational functioning but directed towards the outside. The latter pertains to formal and informal authority: a quadrant that directs its operations downwards is not pegged to formal authority and decision-making chains, while an upward-oriented quadrant is closely supervised. The control and community quadrants operate upwards, as they are not pegged to authority chains *per se*. But they differ heavily in their strategic outlook as regards inwardness/outwardness. The cure and care

quadrants operate along the same lines: both operate downwards, but differ heavily in their inward/outward strategic orientation. The control quadrant operates up and in: it targets operations and seeks control over internal organizational affairs. The care quadrant operates down and in: it must answer the cure quadrant, as nurses are hierarchically subordinates of physicians, and operates strictly within organizational boundaries. The cure quadrant operates down and out: physicians maintain a close grip on their autonomy and do not respond to direct supervision; further, they seek control over operations. The community quadrant operates up and out: it is not beholden to any formal authority in the hospital and does not seek control over operations. These dynamics explain much of what happens in a large hospital.

Chaplains have been in employment by public hospitals for close to three decades. As shown in Chapters 6 and 7, this is no longer the case for all chaplains and is never the case for any non-Catholic representative. As mentioned before, religious assistance is uneasily positioned in the care quadrant: it may be held as a legitimate form of care by nurses, physicians and support staff, or it may not. The uneasy position is also a constant in chaplains' discourse: they are unsure of their role, since, unlike American chaplains, Portuguese chaplains lack access to clinical pastoral education. Thus, their position in the hospital is largely dependent on the community quadrant. They are, in other words, dependent on alternative audiences to gather the resource of legitimacy and attain enough status and reputation. This does not mean that they do not seek recognition from physicians and nurses: they do and their resources are generally used to make claims over the importance of religious assistance in hospital settings. But they never claim that religion is a form of alternative medicine. Indeed, it is always complementary and never veers towards the realm of faith healing. This is due to meaning-making constraints, surely, but is also a function of field organization and power: religious assistance does not question the biomedical settlement directly. Instead, chaplains seek to emphasize two distinct agendas: patient rights and humanization.

At the outset, it is established that SAF theory operates at the middle level. Hospitals are professional bureaucracies where medical knowledge holds a dominant position in defining what is legitimate in terms of boundary conditions. In other words, the cure function of hospitals defines what and who should and could operate within its premises. This is a rule of medicalized discourse and practice. Contemporary medical professional bureaucracies are reinforced by the dominance of a specific mode of medical rationality. Biomedicine excludes any form of non-standardized medical skill. In other words, individuals and groups not

recognized as buying into the biomedical consensus are not included by the incumbent group, which in the case of professional bureaucracies is the operating core, into field boundaries.
The hospital SAF is influenced by the organizational form because it is this form that imbues professionals with the power to perceive settlements as favorable. The dominance of biomedical rationality enforces physician dominance, which subsequently reinforces pressures towards isomorphism. This is why Portuguese public hospitals above a certain threshold are similar. But this does not explain why religious assistance services and regimes in similar hospitals assume different forms. Isomorphic pressure is lower in these contexts. There are two reasons for this. First, the institutionalization of religious assistance into hospital structures is not a linear process, because boundary conditions for religious assistance are less strict: the prime operating mechanism, as regard religious assistance, is not standardization of skills but a mix of mutual adjustment and direct supervision.

Chaplains are not strictly beholden to the hospital hierarchy; instead, they face self-imposed restrictions and are more or less free to pursue their goals as long as they do not disrupt the dominant settlement, which is based on the institution of biomedicine. Second, the pressure to conform is lowered by the significant fact that religion in public institutions is contained by regulatory schemes into static roles and performances. Where actors want out of this containment procedure, problems appear: medical professionals, acting as incumbents, attempt to maintain control over the field of healthcare and the organizational field of hospitals by issuing rules and imposing their discursive frame, based on biomedicine, in order to keep religious assistance out of the operating core. At most, chaplains are seen as members of the support staff. But the role of institutional entrepreneurship and the dynamic character of SAFs in this context open problem spaces where chaplains are likely to argue for their legitimate place as support staff (at least). In this study, interviews show that religious representatives do not attempt to challenge the dominance of incumbents or the ideology of medical professionalism directly. Instead, they look for indirect challenges: the arbitrary secularism of medical practice, the increasing – and empirically verified importance of – importance of holistic epistemologies in medical practice and the contribution of religion to wellbeing. These are not direct challenges to the public healthcare SAF or the hospital SAF. However, the dominance of the operating core in hospitals is sustained by the institutionalization of an exclusionary paradigm.

The problem lies with the centrality of biomedicine and medicalization: the Glouberman-Mintzberg model shows how the cure quadrant in hospitals tends to amass most resources because hospitals are not seen as cure-and-care organizations, but only as cure organizations. Support, in the form of end-of-life care or religious assistance, is seen as non-essential. Conrad and Good's work show that medicalization, in positioning illness and cure as the central problems of modern medical practice, excludes care procedures from legitimate tactics. At this point, the question of legitimacy, status and reputation comes again to the fore. In modern hospitals, religion was seen, until the 1990s, as lacking scientific legitimacy, status and reputation to merit presence in medical settings. While the history of hospitals made full evacuation of religion from their organizational settings difficult – SAFs are, to some extent, path-dependent – modern medical ideology turned the place of religion in its preferred settings difficult. It turned religious practice against religion, by asserting that any non-evidence based practice was akin to faith healing, for example.

In field-theoretic terms, the incumbent-challenger-internal governance unit structure is clear: medical personnel entered into coalition with State agencies, which perceived medical practice and medical facilities as respectively symbols of independence from religion (and quickly became beacons of secularism) and State power. Medical professionals are certified by States and thus buy into a settlement that establishes strong, assertive secularity. If the operating core of a given organization is driven by protection of a settlement that seeks to contain religion, its role will necessarily become fraught with problems of placement and legitimacy. Further, since boundary conditions are not strongly established with regard to religious assistance in hospitals, since chaplains are not pressed into skill standardization, their presence in hospitals is likely the result of institutional entrepreneurship and the institutionalization of religion as a taken for granted, if not always consensual, presence in the organization. Chaplaincies in public hospitals do not need to conform to incumbent-imposed isomorphism; they seek to adapt to existing organizational conditions within two sets of rules that emanate from three different fields in two different scales, the healthcare and the religious field (two meso-level SAFs) and the hospital organizational field (one micro-level field). Entangled in these sets of rules, religious assistants find that their constraints are frequently lower in terms of operational leeway: they are not part of the operating core, so they do not need to concern themselves with output or skill recognition. Concomitantly, they need to deal with the biomedical settlement and the issue of publicness.

The first is a concrete challenge to the role and performance of religion in healthcare settings: biomedicine may be construed as an instance of secularity insofar as it drives incumbents and,

by extension, organizational forms towards social worlds where religion is either a matter of personal choice or a non-essential component of care functions, never a component of cure functions.

Contemporary healthcare operates under the assumptions of the medical model and medical rationality; in that sense, biomedicine is both a core institutional component of the healthcare field and part of its cultural settlement. This brief discussion points to an important question: Norwood (2006) mentions the ambivalence of chaplains in hospitals and Cadge (2012) discusses the strategically vague frame employed by chaplains in hospitals. These concepts emerged from field research in American hospitals. In a Western European non-pluralistic setting, such as Portugal, ambivalence and vagueness are likely to fail: religious assistance in hospitals would be unlikely to sustain its position through strategically vague frames or subjective ambivalence. Illness is defined in exclusively materialist terms, suffering is something to be done away with and patients are simply carriers of diseases. While modern religious assistance asserts its legitimacy by denying any claims to faith healing (indeed, one of the boundary conditions for the religious field is the denial of faith healing as a concrete alternative to biomedicine, and those religious organizations which maintain their belief in faith healing are excluded from the field and seen as illegitimate), it seeks to define illness in non-materialistic terms and looks for support in the work of psychiatrists such as Rogers and Kübler-Ross or in the reconfigured approach to health presented by the WHO since 1978. If biomedicine is established as part of the healthcare SAF settlement, medicalization is a complex driving force towards compliance by organizations and the evacuation of non-biomedical epistemologies: religion in healthcare is not equipped to negotiate medicalization in its own terms because it is constrained by problems of legitimacy and its own core tenets.

This is one of the reasons why religious assistance services in Portugal face difficulties in negotiating their position in hospitals. In each of the three empirical cases researched in this study, an exit strategy could be seen as a way out of the problem of medicalization and biomedical imperialism, as opposed to a voice or loyalty strategy (Brunsson, 1989; Hirschman, 1970) : the first, voice, is likely to be deemed illegitimate by any given audience (religious organizations will likely reject medicalized religion; medical professionals will not compromise with religious assistance services), and the latter, loyalty, would require renunciation of the basic function of religious assistance in hospitals. Importantly, "Medicalization can also grant the institution of medicine undue authority over our bodies, minds, and lives, thereby limiting individual autonomy and functioning as a form of social control (Illich 1976; Zola 1972)" (Barker 2010: 152). If social control is understood in broad

terms, we arrive at the core problem facing religion in public hospitals: medicalization entails the normalization of lived religion and its translation into medicalized, that is to say legitimate, reputable and status-enhancing terms. What is medicalization? According to Barker, it is "the process by which an ever-wider range of human experiences comes to be defined, experienced and treated as medical conditions" (2010: 151). Based on Ivan Illich's initial critique of imperialist medicine (1976) and the work of Peter Conrad (2005, 2007), medicalization is an over-arching process which attempts to frame human life as a series of medical conditions. It is not, however, complete; while biomedicine holds to the promise of completeness, medicalization is an instance of power struggles between manifold groups. Religious assistance is less organizationally constrained than other services and actors in the hospital organizational field but it must nevertheless grapple with the medicalization of everyday life, which offers an alternative narrative and tools for sense-making. Medicalization is the politics of biomedicine.

As W. Richard Scott states, "institutional frameworks define the ends and shape the means by which interests are determined and pursued" (2007) and those institutional frameworks comprise regulative, normative and cultural-cognitive influences or pillars (id, ibid.), public healthcare fundamentally differs from private healthcare because its regulative, normative and cultural-cognitive dimensions are specific to the publicness framework. In this neo-institutionalist account, chaplains, chaplaincies, religious diversity and religion develop in public hospitals within the constraints of publicness as understood at micro-, meso- and macro-levels. Framing the question as such moves us into a consideration of publicness formations and how secularities nest into them.

How do public institutions that theoretically tend towards coercive isomorphism diverge into local orders of religious assistance? A fruitful answer to this lies in the social skill of religious representatives in framing publicness within healthcare. Substantive publicness in a given hospital might be perceived by a chaplain as secularist, leading him to engage in institutional entrepreneurship, employing resources and skill to reframe publicness into a more inclusive organizational regime. In most Western European democracies, normative publicness comprises values which attempt to strike a balance between democratic pluralism and public secularity. Religious assistance in hospitals must face the challenge of asserting its legitimacy in spaces where public secularity is deeply institutionalized. When the normative core of publicness comprises a complete, self-contained outlook on secularity, it is safe to assume that public organizations will show a commitment to the maintenance of those core normative

values. Religious assistance is seen as a challenge to these core values and some groups are likely to politicize religious assistance by claiming that public hospitals which subsidize religious assistance are eschewing their publicness.

Anderson, on the other hand, describes three core components of publicness: "Core publicness describes the ownership or formal legal status of the organization (Scott and Falcone, 1998). Dimensional publicness describes the extent to which the organization is subject to economic and political influence (Bozeman and Bretschneider, 1994). Normative publicness embodies public values, describing the extent to which organizations adhere to public service values (Moulton, 2009)" (2012). These insights suggest that publicness not only needs to be factored into an analysis of religious diversity in hospitals but also explains, to some extent, why religion, contrarily to strong secularization, never fully disappeared from public healthcare settings. While this is not exclusive to healthcare, it is likely that these negotiations and sense-making procedures are more frequent and pronounced in healthcare when religion takes a stand. Hospitals researched in this dissertation are public and seen as attending to universal and egalitarian understandings, and its regulative pillar forces agents in organizations to comply. Chaplains are doubly pressured into accepting institutional control, but engage in different strategies of institutional resistance to resist what they see as an over-medicalized outlook on patients, illness and death. If the publicness regime in a given hospital is represented as standing on the core function of cure ascribed by society to hospitals in general, it is likely that chaplains at that hospital will have a harder time asserting themselves as legitimate actors in the hospital. Chaplains may have a harder time asserting themselves within the hospital, but may at the same time enjoy legitimacy outside the hospital because society holds to a normative and cultural-cognitive publicness regime that emphasizes questions, roles and norms that reinforce the role of chaplains and religion in public hospitals. State-religion relations operates in dimensional and normative publicness, as does State secularity. Healthcare became dominated by an institutional framework that did not exclude religion. This institutional framework created modern chaplains and chaplaincies. It is also the institutional framework where religious diversity and policy responses to it are made possible: without normative public values that underline the importance of liberal democracy, religious diversity would like never have emerged as a question for organizations to solve.

CHAPTER 4: Literature Review

In this chapter, I review the literature on four topics: religion and public policy, religion in public institutions and religious assistance in hospitals. This chapter is a literature review of State-religion relations, health systems organization (with an emphasis on the organization of hospitals) and religious assistance in healthcare settings. The latter is the core of this chapter: the review of the literature follows a downward perspective. State-religion relations is the macro-level institutional arrangement which frames religious assistance in hospitals. Hospitals in health systems organization are the mid-level organizational settings where religious assistance actually occurs. And, finally, religious assistance itself is the fundamental topic of this dissertation.

4.1 State-religion relations

State-religion relations are institutional arrangements which mediate the relationship between formal or informal civil society groups which identify themselves as religious and those groups, organizations and agencies which make a plausible claim of belonging to the inner perimeter of the State. Contemporary institutionalized State-religion relations are the result of protracted struggles in Western Europe which span several centuries and are usually held to be one of the defining features in State-building phases (Crouch 1999; Fernandes 2009; Gorski 2000; Gorski and Altinordu 2008; Madeley 2003, 2009).

State-religion relations tend to follow two lines of inquiry. One is focused on legal analysis and other is comparative historical. These are complementary and there is overlap in most State-religion analyses.

Legal studies of State-religion relations tend to start from the assumption that legal-formal dimensions are a close reflection of existing settlements in the religious field and long historical processes. The legal-formal category is illustrated in Gerhard Robbers' (1996) and Silvio Ferrari's work (Ferrari 2003, 2005; Ferrari and Bradney 2000; Ferrari and Cristofori 2010). These studies conceive of institutions as rules of engagement embedded in legal systems. As such, units of analysis generally comprise political constitutions and legal rules, provisions and norms drafted and enforced in the context of State-religion relations. This is a classic approach to politics and, to a large extent, the existence of civil and canonic law systems illustrates the importance of State-religion relations and functional differentiation to not only current political structures (at the level of polity, policy and politics) but also the study of those same structures. Moreover, it is convincingly argued that processes leading to State-building and derived from

it are now institutionalized in legal systems, themselves embedded products of historical legacies and struggles, an assertion that should prevent any extreme disavowal of legal exegesis as a basis for further research. Nevertheless, it is important to recognize the preeminence of positive legal thinking in Western Europe. It has, to a large extent, crowded out more interpretive and historically sensitive approaches. It also kept legal scholars engaging with State-religion (or, in a more geographically apt description that is becoming less precise, Church-State) relations attentive to the letter of the law and relatively inattentive to underlying or concomitant social and political processes (Robbers 1996). These do not only shape institutionalized norms and rules of engagement; they also define and modulate debates on ideal and/or existing State-religion relations, as well as defining how and why actors justify their actions.

This body of scholarship tends to equate legal provisions with their application (Ferrari 2000, 2005; Nielsen 2009). The traditional threefold categorization of Church-State relations models in Western Europe, comprising concordatarian, state-church and separatist institutionalized modes of interaction is a direct effect of this approach. While its limits have been increasingly shown in the literature by other legal scholars (Ferrari 2000, 2005) and more historically-minded authors (Driessen 2014; Nielsen 2009), this typology is still used as a reference point and leads to severely problematic mischaracterizations of cases (e.g. Belgium, Greece, Ireland and post-disestablishment Sweden) or inappropriate bundling (United Kingdom/Norway/Denmark or (including cases outside Western Europe) the USA/France/Turkey). More recent studies, particularly Fox (2008), Kuru (2009) or Stepan (2011), focus more on the coding of legal systems into measurable indicators than on the qualitative analysis of legal documents. This has led to a number of proposals regarding State-religion relations typologies which point to the limits of the threefold typology.

The comparative historical category is a contextual approach which surmises that comparative historical analysis is an appropriate way of linking the legal dimension of State-religion relations to its politics and power struggles. It implies a balanced perspective on the development of relationships between different actors. It emphasizes underlying socio-religious characteristics and trends. In doing this, the historical approach captures the context and dynamics of change (Collier et al 2010; Tilly 2006) and allows scholars to discuss long-term processes. Studies in this tradition are likely to provide context-heavy case studies and where possible, provide new challenges to the traditional threefold typology (e.g. Casanova 1994; Gorski and Altinordu 2008; Madeley 2003, 2009; Madeley and Enyedi 2003). In this approach, religion becomes more than a socio-political identity marker used to define a group

and determine its standing in relation to the State. It is a belief system embedded in a large number of institutions (Bevir and Rhodes 2010) and a social institution with a specific salience which is related to sociological and historical dynamics (Davie 2007). However, because of the path-dependent character of State-religion relations in most Western European polities, where elite mono-confessionality determined a formal and informal monopoly by one religious community (the Catholic Church is a prime example), the historical approach usually emphasizes internal stability and homogeneity (Madeley and Enyedi 2003; Soper and Fetzer 2005, 2007), which is common to macro-oriented approaches (Mahoney and Thelen 2010). What this means is that, by emphasizing a higher level of analysis, the historical approach to State-religion relations is not particularly sensitive to struggles for change within institutions, whether by power redistribution or conflict over dominant interpretative frames (Weible et al. 2011; Schmidt 2008). It is consensual that State-religion relations are highly sensitive to societal developments and develop symbolically (Bourdieu 1970; Rey 2007; Weber 2006). Historically-oriented scholars construct State-religion relations as an institutional arrangement with an inbuilt tendency toward equilibrium and changing through linear processes (Madeley 2003, 2009). As such, State-religion relations research in this tradition is closely related to comparative research such as the "family of nations" framework as devised by Francis Castles (1993; Castles and Obinger 2008) or Esping-Andersen (1990) and applied to the confessional map of Europe (Madeley 2003, 2009; Madeley and Enyedi 2003; Minkenberg 2003, 2007). Catholic nations thus become cases of non-pluralistic selective cooperation partnerships. These historical allegiances between the Catholic Church and the State determine the entrenchment-through-concordat of a dominant interest group (as seen in less systematic works such as Manuel (2002, 2014), Manuel et al. (2006) or Wiarda and Mott (2001). In this tradition, large-scale critical junctures, e.g. the Treaty of Westphalia or the 1905 French Law on Separation), are frequently mentioned but rarely treated as actual critical junctures, namely as key periods in time where a number of possibilities with equal chances of locking in emerge (Collier and Collier 1991; Pierson 2003, 2004; Mahoney and Thelen 2010, 2015). These events are usually conceived as notional "Big Bang" events, where everything occurring afterwards is a direct or indirect effect of the sudden openness in political opportunities, or as anecdotal events which relevance has been established through historiographic authority and merits only a brief reference among the larger and slow-moving trends of religion. Some works in this tradition are historical accounts without explicit methodological or theoretical choices and assumptions and scholars adhering strictly to it tend to emphasize description without attempting to make

explanatory claims or analytic inferences about their topic[1]. Most accounts of Portuguese State-religion relations fall into this subcategory, which folds into the threefold proposal. Carvalho (2013), Matos (2011), Ferreira and Matos (2013), Reis (2006), Teixeira *et al.* (2012) exemplify attempts at either non-systematic historiography or quasi-comparative analysis.

The comparative historical analysis of State-religion relations may be of a more systematic sort.. Several studies in this tradition seek a midlevel compromise between the strict textual analysis of legal documents and the large-scale study of developing relations between religious traditions and States (Kuru 2009; Stepan 2011; Stepan and Taylor 2014). As a result, State-religion relations are no longer abstract legal systems, rules or norms nor are they high-level historically stable and immanent features of polities. State-religion relations are institutional arrangements which mediate patterns of interaction between actors (Stepan and Taylor 2014), namely religious communities at various power-distributional levels and State officials. Those arrangements are legally institutionalized, embedded in political life and constantly framed by other debates, especially those that pertain directly to historical legacies of interaction between religion and the State. The provision of healthcare in Western Europe was largely an enterprise taken by religious communities until the emergence of welfare states (Esping-Andersen 1990, 2011; van Kersbergen 2009). Importantly, State-religion relations as studied in this tradition do not necessarily tend towards equilibrium and are not linear. Instead, they are always the object of power struggles and always embedded in larger dynamics of State-building/redeployment (Fernandes 2009; Gorski and Altinordu 2008; Philpott 2007). The political approach to State-religion relations is an evolutionary step from legal and historical accounts. It allows for the usage of State-religion relations as the effect or cause of any theoretically plausible phenomenon. Related to our study, it thus becomes possible to posit a scenario where the currently existing legal apparatus, as well as the historical legacies which inform and contextualize it, explain how and why religious communities participate in a specific stage of the policymaking process in healthcare. It also provides a sound basis for the analysis of religious assistance in hospitals as a microlevel instance of State-religions relations.

State-religion relations are not only institutional arrangements but also complex historical legacies with structural and symbolic features which come to define discourse and action repertoires enacted by whichever groups compelled to act within the policy fields plausibly affected by them. This approach avoids reductionist and deterministic understandings of

[1] Case-specific literature on State-religion relations in Western Europe is, as a consequence, enormous and mostly inconsequential to comparative studies on other cases.

"models" (Bader 2007) which overstate systemic integration and take State-religion relations as a deterministic and closed system. The comparative historical approach avoids this by taking non-linearity, power struggles and socio-cultural embeddedness as endogenous. Increased complexity has led to the use of State-religion models in a growing number of studies which attempt to discuss them as independent variables (e.g. Fox 2008; Minkenberg 2003, 2007; Shadid and van Koningsveld 1995, 2002; Soper and Fetzer 2005; Stepan 2011; Tatari 2009).

In conclusion, the comparative historical approach to State-religion relations emphasizes policy legacies, path dependency, positive feedback and increasing returns (Collier and Collier 1994; Farrell and Crouch 2004; Mahoney and Thelen 2010; Pierson 2003, 2004; Steinmo and Thelen 1992; Thelen and Streeck 2005). It also makes the claim that existing structures are the effect of protracted power struggles and debates on ideas and discourses that develop according to a general set of rules and ideational outer limits, defined by concomitantly evolving State-religion relations. Therefore, current structures and events are a nondeterministic function of previously existing structures and events (Crouch and Farrell 2004; Mahoney and Thelen 2010).

As a consequence of its departure from legal and non-systematic historical studies, the political approach attempts to explore linkages between State-religion relations and polity structures (e.g. Madeley and Enyedi 2003; Minkenberg 2003; Soper and Fetzer 2005, 2007). Others recast State-religion relations in supply-side economics terms and test public-choice theoretic hypothesis on religious vitality as the independent variable (e.g. Iannacone 1992; Stark and Finke 1988; Iannacone et al 1997). An important body of literature attempts to discuss group-specific opportunity structures, usually regarding Islam in Europe (Cesari 2004; Cesari and McLoughlin 2005; Ferrari 2000, 2005; Fokkas 2007; Koopmans and Statham 2005; Maréchal 2003).

4.2 The policy process and State-religion relations

State-religion relations, for the purpose of this study, is a set of historically located and determined institutional arrangements which mediates relations between different groups and agents by means of legal provisions and formal/informal political relations (Kuru 2009; Stepan 2011; Stepan and Taylor 2014). This set of institutional arrangements is always embedded in broader social and political relations, values, attitudes, behaviors and structures. State-religion relations are hybrid sets of institutional arrangements because they mediate relations at various levels, namely the symbolic, structural and relational, and their causal linkages to policy should

account for the fact that they operate not only as exogenous to policy but also endogenously. That is to say that State-religion relations are not only causes of existing policy structures, but they are also constitutive of existing structures, debates and decisions.

The legal component of State-religion relations, as constitutional and legal provisions, is linked to health policy in two ways.

First, through the regulatory framework it provides for recognition of religion as a preeminent sociopolitical identity, for example by institutionalizing a State-church pattern (e.g. Norway) or accepting the coexistence of non-confessionality and concordats, thereby establishing a monopoly (e.g. Portugal). Madeley and Enyedi (2003), Stepan (2011, 2014), as well as the landmark study of Fox (2008) support this general provision. Second, by regulating and normalizing religion within public health facilities (as well as within private health facilities, even in the case of religious hospitals). This concerns legally mandated and enforced provision of religious services in public health facilities, such as prayer spaces, religious care workers and spiritual counseling, regulations on garments for staff members, observed holidays for staff members, dietary requirements related to religious beliefs, respect for constrains on clinical procedures imposed by religious belief (e.g. restrictions on blood transfusion in the case of Jehovah's Witnesses) and ritualized palliative/end-of-life procedures. Moreover, if existent legal provisions point to the necessity of seeking inputs from religious communities, either as such or as patient organizations, this is in itself a direct effect of the legal component of State-religion relations.

State-religion relations operates by determining the lower and upper levels of religious community influence in the policy process. This occurs in two ways. First, the power position of religious communities in the policy process is defined by State-religion relations insofar as it provides opportunity structures to those actors and conditioning the use-value of their symbolic and material resources (Fligstein and McAdam 2012; Chapter 3, this dissertation). Second, it defines and constrains the choice set (Knight 1992) of all actors involved in the policy process. Since power distribution is an effect of historical legacies and is highly unequal, especially in contexts of emergent societal diversity and established mono-confessionality, such as in Ireland, Norway and Portugal, this structural constrain increases positional disparities among religious communities (Bourdieu 1971; Rey 2007). Health policy will therefore largely attend to the needs of the dominant religious community and institutional change will likely be an effect of brokerage by that dominant group (Beckford 1999; Furseth 2003). However, besides allowing for the possibility of exogenous shocks as change inducers (Thelen and Streeck 2005), one should account for the possibility of emergent coalitions

(Weible et al. 2011) of minority religious communities and official actors or institutional redundancies and contradictions (Crouch and Farrell 2004) within State-religion relations or the wider health policy field that create endogenous shocks. This leads to the second causal linkage between State-religion relations and health policy. In contexts of emergent religious diversity, and assuming that liberal democracies accommodate it to some extent, institutional responses to this challenge will depend on the adaptiveness of existing institutional repertoires and the power structure of the field itself. Following our discussion on the historical dimension of State-religion relations, the relationship between religious communities will be mediated by those repertoires that are represented as most appropriate. Policy learning effects (Hall 1993) and feedback effects (Pierson 2004) ensure that State-religion relations are, as a rule, employed in mediating relationships between religious traditions and the State. For example, if at a given starting point, religious workers of a certain tradition are paid by the State to provide spiritual care at a hospital and, at a given point in the future, that arrangement is extended to other religious communities, it follows that institutional adaptiveness allowed for an extension of rights. These movements towards extension of rights are commonly functions of preexisting limits to their enactment. Exceptions exist, as symbolic policy fields are sensitive to policy learning effects (Hall 1993; Minkenberg 2003). This framework applies to situations where preexisting monopolies or quasi-monopolies exists, whether in the form of single-confession State-funded religious workers or single-confession prayer spaces in public health facilities. Existing norms and practices that are not necessarily enforced nor prohibited by law, e.g. circumcision or specific palliative care, will most likely be extended only after extensive lobbying by religious communities or through brokerage provided by the dominant religious community (Beckford 1999; Beckford and Gilliat 1999; Furseth 2003; Griera and Martinez-Ariño 2015). It is also extensible to venues where policy formulation occurs, as a minimum threshold of institutional adaptiveness is needed to include new communities in the policy process regardless of the willingness of other actors.

4.3 The politics of hospital governance in Portugal

For most of medieval and modern European history, healthcare provision was performed by religious organizations. The traditional church-State cleavage, as identified in the seminal works of Lipset and Rokkan (1967), is partially linked to this historical pattern. The work of Kersbergen and Manow (2009) illustrates this relationship, as does Davie (2007). Religion as a social institution is traditionally connected with the provision of health and care for the ill.

In a meaningful sense, religion may be understood as a health support system, both socially and psychosomatically; in Latin Christendom, this is particularly relevant, as religion remained the most important social institution and the Roman Catholic Church the most important private actor. Southern European welfare models continue to rely heavily on subsidizing care provided by religious organizations, and the Roman Catholic Church in countries such as Portugal has protected this institutional arrangement as both right and privilege. The role of religion in healthcare was widespread and, to a large extent, the status, reputation and legitimacy of religion as social institution has been historically linked to its position as response to critical life stages: birth, dying, death and bereavement. In order to fully comprehend the role of chaplains and religious diversity in public healthcare, the role of religion in providing health, discursively or institutionally, needs to be understood.
The work of Risse (1999) is revealing in this regard. Healthcare, as social function, is religious. It seeks to "mend bodies and souls", and much of Latin Christendom's history may be investigated as the history of health provision. While the Roman Catholic Church asserted itself as a political actor in late antiquity, its role as the institutional umbrella under which sites of healing operated gave it much of the political weight it eventually gained. The case of Portuguese healthcare is revealing in this regard. The emergence of the Portuguese State is as much connected to the exertion of monopoly over the exaction of justice and violence as it is about gains in legitimacy derived from the provision of social goods; conflict over the politics of provision went on for two centuries against the Roman Catholic Church. As Church power faded into civil society, it strove to keep its institutional network, sometimes at the expense of overt political claims to power. The interpretation of Carolyn Warner (2000) should be taken cautiously in this regard. As an organization, the Church engaged as much in rational decision-making as in sense-making on the basis of its self-avowed mission. The politics of religion in healthcare should be seen in this regard. In contemporary Portugal, the maintenance of hospitals managed by religious orders is not simply a function of conservative backlash against full-scale nationalization or a function of neoliberal privatization policy.

Hospitals, as McKee and Healy (2002) suggest, are symbols of State power. In three different revolutionary periods (1822, 1911 and 1974), the provision of healthcare became heavily politicized. The emergent State sought to remove the governance and provision of healthcare from private actors to its core functions. In hindsight, it largely succeeded, as the Portuguese health system operates as a Beveridgean National Health System with large budgetary outlays

to specialized institutions, such as local clinics and hospitals. This is independent from the type of regime: the constitutional monarchy strove to claim hospitals from the Church, as did the 1911-1926 Republic and the current democratic regime; under fascist rule (1933-1974), new hospitals were built in order to stake a claim on symbolic power by the State.
These events are significant because they illustrate a shift specific to healthcare and allow us to locate chaplains, chaplaincy and ultimately religion in the field. One may think about the provision of healthcare as initially dominated by religious organizations, where caring for bodies was only as important as caring for souls or some spiritual component of human beings – chaplains were scarcely needed, as there was no intra-organizational boundary between care, cure or community, and there was no split between holy bodies or medical bodies. Social interactions and phenomena were not medicalized. Religious assistance in hospitals made no sense as institution, since it lay at the core of what places of healing did. As science emerged as an alternative paradigm, but long before it became able to contest the primacy of religion – indeed, before religion became one option among others, as suggested by Taylor (2007) -, medical practice became less dependent on religious assumptions and more dependent on the politics of care. States opted to support medical practice and nascent medical disciplines in order to make a political claim to power through healthcare provision, but religion was never removed from healthcare, as religious organizations successfully made a claim for their proficiency in attending matters of health. Hospitals are thus places where secularity is apt to be observed in the *longue durée*, as organizational secularities were imposed through the sponsorship of medical knowledge where religion not only was seen as illegitimate but also had very low reputation. However, religious organizations were able to maintain many of their core functions as institutional functions.

At this stage, chaplaincy as an organizational function becomes visible. This reversal is one of the more interesting features of chaplaincies as institutions. They only become visible as religion stops being part of organizational *doxa*. While the ministry of presence, as put by Sullivan (2014), is seen as recently emerging, it has deep historical roots. This reversal is not an instance of strong secularization, but it points to the chaplaincy as a focal point in the study of public institutions and the place of religion within it. Chaplains and chaplaincies only become visible when religion is no longer institutionalized into healthcare. Chaplains and chaplaincies only become visible as religion becomes contested, but there are very few instances in Western Europe where chaplains are absent from public hospitals. The contexts of action constructed by the presence of these individuals and institutions are instances of

lived religion within places where religion has long held a resonant, meaningful role. One may argue that religion gave place to publicness as a meaning-making device. This is a disputable claim, which this study will argue for. Is the fact of public ownership relevant in the context of healthcare? What makes a public organization different from its alternatives in sociological terms? The simplest answer would be that it makes no difference whether a hospital is public or private: its regulatory environment (Edelman 1992), outputs and societal functions are similar. The public/private divide makes little sense because it is based on ownership attributes. What varies is the commodification of healthcare, as for-profit hospitals are certainly different from public and/or non-profit hospitals. What we find in existing cases, however, is that public hospitals are constrained by their regulatory environments. In Portugal, these hospitals must provide religious assistance to patients if they choose to request it..

4.4 Religion in public institutions

In a volume coordinated by Bender et al (2013), a four-edged research agenda is presented in order to advance the sociology of religion from its traditional topics and sites of research. The four edges are "Provincializing the United States" (Bender et al 2013:1-4), "Beyond Christo-Centrism" (id.: 5-7), "Religion Outside of Congregations" (7-10) and "Critical Engagements of Religion" (10-13).. As Bender et al state, we strive towards "looking "beyond" the congregation as a way to open up sociological approaches to the organization, scope, and development of religion in society. Therefore, "(…) moving beyond the congregation does not mean merely calling attention to non-congregational religious life and production, especially if this means (as it all too frequently has) identifying the kinds of religious actions that take place outside of congregations as "ordinary" or "everyday life" religion that complements, or resists or somehow goes on "despite" or "in addition to," congregational and voluntary organizational religion" (Bender et al 2013: 8). It is important to note, however, that "(…) research that investigates how religious life is enacted in the workplace, in the schoolyard, on the bus, in government, and in health care organizations does more than show that religious people take their religious lives with them into various "secular" places. It shows how religious concepts and ideas are often produced (as well as reproduced) in arenas where individuals with sometimes very similar and sometimes very different religious beliefs and practices cooperate or come into conflict as they try to live together." (Bender et al. 2013: 9). If religious concepts, ideas and practices are influenced by the sites of their production, it is also of note that these

concepts, ideas and practices arise at an intersection between a specific configuration of the religious field and the institutional world in which religion is deployed into. As put by Nancy Ammerman (2007: 6), "we are interested, then, in describing the social worlds in which religious ideas, practices, groups, and experiences make an appearance. We are interested in describing what religion itself looks like—that is, in developing better definitions and indicators".

Religious representatives work through difficult contexts in order to establish a new role for religion in science-dominated organizations, adapting their discourse, forming coalitions and negotiating emerging medical fields where they locate gaps in which religion could be perceived to have a role. In this paper, we study these topics at the intersection between the structure of healthcare and the structure of the religious field. In that sense, the third edge is a sociology of displaced religion as much as it is a sociology of adaptation. Religious representatives adapt to organizational boundaries and demands, adapting religion in doing so. But organizations also adapt, as they meet the challenge of changing religious practice within their boundaries. There is unlikely to be a balanced adaptation: religion is not the prime identity in a hospital and its representatives hold few resources to assert their claims. Hospitals may not adapt towards accommodation; instead, they may adapt in order to countervail adaptation by religious representatives which is seen as detrimental to the underlying power structure of the organization.

Religious communities have been the most important health service providers, public or private, for much of Southern European history. They have also been, by and large, the most important civil society members in policy venues throughout Europe, and remnants of that historical legacy have a discernible impact even in EU politics (van Kersbergen et al. 2009; König, Daimer and Finke 2008). While many policy fields are informed by this historical legacy, health and education are arguably structured around the legacy of provision of health and educational goods by religious organizations. The presence of religious communities in educational services is also historically monopolistic (e.g. Ferreira *et al* 2006; Sakaranaho 2006; Skeie 2006).

The strength of historical legacies largely determines how the political-institutional dynamics of religious community involvement plays out. The influence of religious communities in the policy process is dependent on State-religion relations because it provides the framework of overlapping political and discursive opportunity structures for influence to be used; it also defines the use-value of influence and how influence is framed. This accounts for the constrains

imposed on choice sets and perceptions of collective actors in the policy process. At system-level, the political-institutional dimension relates to the operationalization of legal provisions for participation of religious communities, as such or as members of civil society, namely patient organizations in different councils or committees. As in the previous section, where causal linkages between State-religion relations and health policy are discussed, that set of institutional arrangements is a key determinant of institutional adaptiveness, an important feature of political systems and subsystems in contexts of rapid societal change and especially increasing diversity. If an institution is sufficiently adaptable, it will be more likely to allow new religious communities to participate in policy formulation, which is to say that there is room for accommodation within a space which is already internally and externally defined. It will also be more likely to reform, in other words, to expand that space and reshape it according to inputs from stakeholders. The reconfiguration of political-institutional structures for the regulation of religious freedom and provision of extended rights to religious communities in Portugal, after 2001, is a clear example of this.

4.4.1 Religion in hospitals

Hospitals are instances where researchers may observe religion outside religious organizations, the interplay between religion and other knowledge systems and the contemporary role and function of religion. Hospitals are complex organizations where knowledge and type of knowledge determine the power structure. Medical power is based on a specific claim to power by doctors, nurses and managers; religion disrupts the distribution of power and, by extension, the intra-organizational worlds of the hospital by asserting itself as both a knowledge system outside the scope of science and outside the dominant mode of oversight in hospitals. Since doctors cannot prove or disprove religious representatives' claims to care and knowledge, their position facing these representatives is less certain than facing nurses or managers. Given the contemporary organization of hospitals, which emphasizes managerialized care and patient-centered operations, relying implicitly on a stance towards human nature as encompassing religious and spiritual aspects, it is religion that finds itself in adaptive mode. Hospitals adapt to very limited extents and only when mandated by centrally-enforced regulatory standards.

This is a clear development from reactive mode, which forced religion to enclose itself in very limited physical and discursive space within the organizational setting of hospitals. Being able to adapt, religion and its representatives are not necessarily constrained as key to the heal/care

mission of hospitals; chaplains are not strictly speaking medical staff and chapels or prayer rooms are not medical wards, even if some religious representatives seek to legitimize their role in hospitals by framing themselves as healers of sorts. The inherent uncertainty of the place of religion in hospitals is one of the explanatory possibilities of why three public university hospitals in Portugal with a single religious assistance regime show different patterns of religious assistance provision. Literature on State-religion relations tends to overlook the recognition-accommodation nexus, especially as it occurs in concrete institutional settings, and religious diversity, being first and foremost an issue of recognition, seems to be taken as a feature of societies instead of being actively constructed by States. This problem space is larger in less researched contexts. Many exchanges on multiculturalism and excursions into interculturalism suffer from institutional indeterminacy and a clear, empirical look into actual lived religious experience. Parekh (2002), Modood (2009) and Modood (2013) look, respectively, at the philosophical structure of arguments for cultural diversity, the political underpinnings of multiculturalism and claims-making by religious (e.g. Muslim) minorities. But these studies do not go into the detail of what goes on in institutions, except – and not commonly – in schools. Research on the prison system is more advanced in this respect, as Beckford and Gilliat (1998), Furseth (2003), Khosrokhavar (2014) or Béraud, de Galembert, and Rostaing (2013) have provided insight into these topics. The military has been the object of some research (Bertossi 2007; Hansen 2012, Michalowski 2015, Waggoner 2014). Research in healthcare is more difficult to appraise, since interest in the therapeutic value of religion and spirituality has been a staple of medical research since the 1990s, thanks to the work of Harold Koenig (1998, 2009, 2014) and a large volume of studies on emotional health, spiritual wellbeing and other concepts. A growing body of research in the United States has also started the process of filling the gap: studies by Cadge (2013), Cadge and Sigalow (2013), Cadge, Freese, and Christakis (2008) , Norwood (2006), Lee (2002) and Sullivan (2014), among others, seek to explore the lived experiences of hospital chaplains and spiritual directors in American institutional settings. However, sociological accounts of religious diversity in Western European public institutions construct religion as separate from its concrete instances in institutional life: research tends to look into how religious identity interacts with norms about publicness and secularity as something brought from the outside – society, as it were – into bounded systems – institutions. An initial stage of perfect secularity is assumed; in this context, Asad (2003) writes of secular formations which never fully evacuated religion from institutions. Indeed, religious diversity must be conceived as internal to public institutions because there is no evidence of perfect secularity anywhere, apart from writers, mostly

European, who are not sensitive to the embeddedness of religion in public institutions in many contexts and do not see religion as a changing institution itself. In these accounts, which may be variously labeled as radical secularist or orthodox laicist, the emergent, context-bound forms that religion takes as it is deployed or redeployed into public institutions, is nowhere to be found.

State responses to religious diversity may be categorized as paradigmatic, and much research has proceeded in this fashion. From the work of Brubaker (1992) to Kymlicka (2007) or Madeley (2003) and (Minkenberg 2003, 2007), the notion of national regimes or broad-scale policy paradigms has taken hold, and there is much to commend in these classic studies. Further studies show that State responses to religious diversity are likely to be very complex in their concrete manifestations. Research on Islam has shown as much (Cesari 2004, Laurence 2009; Maréchal 2003, Nielsen 1992). But concrete organizational responses to religious diversity take the form of local orders which may stray far from centrally-enforced regimes. This is not the expected outcome of policy change, which is driven by a commitment to standardization, particularly in high-level organizations such as the hospitals studied in this dissertation. The concept of negotiated orders, as discussed in Fine (1984), Maines (1982) and Strauss (1988), among others, is key here. These negotiated orders, in the context of organizational responses to religious diversity and religion more generally, are important in two respects. First, they are manifest in concrete bounded settings. These negotiation contexts occur in structural contexts. Negotiations are held in these negotiation contexts (Maines 1982: 270). This is why case studies of organizational responses to religious diversity make sense. Second, local orders are those organizational features that make highly regulated organizations, such as hospitals, sociologically specific. In other words, they become cases insofar as they are governed by local orders, which might hold very different relationships to higher-level orders. The healthcare policy system is a good illustration of these institutional dynamics.

4.5 Biomedicine and medicalization

Biomedicine is a truth claim employed by medical professionals. As stated by Good, "the "medical model" typically employed in clinical practice and research assumes that diseases are universal biological or psychophysiological entities, resulting from somatic lesions or dysfunctions" (1992: 8). As such, "the primary tasks of clinical medicine are thus diagnosis – that is, the interpretation of the patient's symptoms by relating them to their functional and

structural sources in the body and to underlying disease entities – and rational treatment aimed at intervention in the disease mechanisms" (id: ibid.). Biomedicine is therefore a basic epistemological claim. It asserts the exclusive biological origin of illness and, by extension, tends to perceive patients as fundamentally biological subjects which are to be cured. "Medical knowledge, in this paradigm, is constituted through its depiction of empirical biological reality. Disease entities are resident in the physical body (…) Medical theories reflect the facts of nature, and the validity and rationality of medical discourse is dependent upon the causal-functional integration of biological systems" (ib: 8-9). With these definitional terms, we begin to see how the biomedical frame might work to the exclusion of alternative epistemologies and exert political pressure to render organizational membership by religious assistance illegitimate. Religion holds no role at all in biomedical truth claims. Furthermore, "this broad perspective [biomedicine] has the status of a kind of "folk epistemology" for medical practice in hospitals and clinics of contemporary biomedicine. A person's complaint is meaningful if it reflects a physiological condition; if no such empirical referent can be found, the very meaningfulness of the complaint is called into question. Such complaints (…) are often held to reflect patients' beliefs or psychological states (…) which may have no grounds in disordered physiology and thus in objective reality" (id: 9-10). Thus, biomedicine becomes a taken-for-granted cultural norm in hospitals: it grants legitimacy to its practitioners and those who are especially adept – specialists – garner status and reputation. They come to dominate the operational core of the professional bureaucracy and every other organizational component, including the strategic apex, needs to conform to the tenets of biomedicine. Contemporary healthcare operates under the assumptions of the medical model and medical rationality; in that sense, biomedicine is both a core institutional component of the healthcare field and part of its cultural settlement. This brief discussion points to an important question: Norwood (2006) mentions the ambivalence of chaplains in hospitals and Cadge (2012) discusses the strategically vague frame employed by chaplains in hospitals. Frames employed by chaplains in hospitals are vague in order to decouple their action from traditional chaplaincy and to open up their pool of eligible patients. When a chaplain purports to provide spiritual care or solace, he or she is no longer working within the demands of a particular religious tradition – perhaps through claiming that certain sacramental requirements are mandatory -; instead, a strategically vague frame redefines the scope for action by a religious representative by claiming that every human being is of a spiritual nature and has spiritual needs, thus making chaplaincy more of a ministry of spiritual presence and support than that of an individual bound by tradition. This is a vague discursive frame that may serve the strategic needs of religious assistance in contexts

where religion is no longer perceived as tolerable within a healthcare facility or where religious representatives see a strategic advantage in connecting their presence to measurable impacts on health and wellbeing, particularly if those impacts are translated into psycho-affective terms which are more easily seen as legitimate in healthcare contexts.

These concepts emerged from field research in American hospitals. In a Southern European non-pluralistic setting, such as Portugal, ambivalence and vagueness are likely to fail: religious assistance in hospitals would be unlikely to sustain its position through strategically vague frames or subjective ambivalence. Biomedicine, as a settlement, is a complete description and explanation of human behavior; in that sense, it is parallel to secularism because it eschews transcendence or metaphysics. In settings where biomedicine is the monopolistic explanation of medical conditions, it likely forces religious assistance and its providers into strategic orientations towards a) changing the settlement or b) reframing operations. The issue of medicalization complicates these possibilities, as biomedicine does not lay within the boundaries of healthcare or hospitals.

What is medicalization? According to Barker, it is "the process by which an ever-wider range of human experiences comes to be defined, experienced and treated as medical conditions" (2010: 151). Based on Ivan Illich's initial critique of imperialist medicine (1976) and the work of Peter Conrad (2005, 2007), medicalization is an over-arching process which attempts to frame human life as a series of medical conditions. It is not, however, complete; while biomedicine holds to the promise of completeness, medicalization is an instance of power struggles between manifold groups. What interests us here is its connectedness to biomedicine and how it serves the purpose of reinforcing biomedicine beyond the boundaries of health-related SAFs. The reasoning behind this is the following: if religious assistance is less organizationally constrained than other services and actors in the hospital organizational field, it must nevertheless grapple with the medicalization of everyday life, which offers an alternative narrative and tools for sense-making. In a meaningful sense, medicalization is the politics of biomedicine. It enables professionals to question and disable the presence and living of religion within hospitals and healthcare, even if most religious organizations are clear in their rejection of faith healing and approval of biomedicine as a primary healing methodology. The emergence of a voluminous body of work on the negative? effects of religiosity on psychophysiological states, in particular the works of Harold Koenig, attests to this approval. Furthermore, the increased focus on spirituality – which lies at the core of the strategically vague frame proposed by Wendy Cadge –, wellbeing and patients' rights are evidence of shifts in understandings of cure and care by religious organizations. An important issue with

medicalization lies in its consequences: “By defining disease as a biological disruption residing with an individual human body, medicalization obscures the social forces that influence our health and well-being” (Barker 2010: 152). If biomedicine is established as part of the healthcare SAF settlement, medicalization is a complex driving force towards compliance by organizations and the evacuation of non-biomedical epistemologies: religion in healthcare is not equipped to negotiate medicalization in its own terms because it is constrained by problems of legitimacy and its own core tenets. This is one of the reasons why religious assistance services in Portugal face difficulties in negotiating their position in hospitals. In each of the three empirical cases researched in this study, an outward strategic orientation could be seen as a way out of the problem of medicalization and biomedical imperialism, as opposed to a commitment to the hospital and its cure or care functions. If religious assistance services were to employ the former orientation to its fullest extent, it would be tantamount to a full rejection of religion in hospitals, as chaplains or religious assistants would exit the organization completely and would be permanently locked out of hospital operations. If religious assistance services were to employ the latter orientation to its fullest extent, it would be tantamount to signaling the irrelevance of religious assistance in hospitals, which would go against their commitment to survival as religious representatives within hospital premises and the development of religion outside its traditional venues. A balanced strategy is required in order to express loyalty to the religious assistance endeavor itself and actually existing modern hospitals. So as to not cross the line into renunciation, a strategy akin to the one pursued by Hospital C Spiritual and Religious Assistance Service would need to be pursued. It expresses loyalty by accrediting itself as a hospital support service, but does not distance itself from religion. Importantly, “Medicalization can also grant the institution of medicine undue authority over our bodies, minds, and lives, thereby limiting individual autonomy and functioning as a form of social control (Illich 1976; Zola 1972)” (Barker 2010: 152). If social control is understood in broad terms, we arrive at the core problem facing religion in public hospitals: medicalization entails the normalization of lived religion and its translation into medicalized, that is to say legitimate, reputable and status-enhancing terms. Seen as a form of social control based on a complete, self-contained ideology such as biomedicine, one may posit a connection between the specific organizational secularity of hospitals and medicalization. The modern hospital SAF is unlikely to accommodate religion because its organizational key component part, the operating core, is also the incumbent in the SAF; the biomedical settlement assigns dominance to incumbents as a set of institutionalized beliefs and practices that resonate

and translate into broad social consensus. Religious assistance in hospitals is therefore highly dependent on institutional entrepreneurship and coalition-building.

4.6 Conclusion

This chapter is a literature review of State-religion relations, the politics of hospital governance as a core function of health policy and the complex configuration of religion within healthcare, namely in its instantiation as religious assistance.

State-religion relations are causally linked to the health policy process via direct (legal and political) and indirect (historical and political) linkages. They define, among other issues, the rules of engagement for religious communities as social groups and service providers, the framing of symbolic policy measures, the range of available policy measures, the power structure in health policy, the availability and use-value of resources by communities and the choice set of those communities. These theoretic underpinnings are not exhaustive and are subjected to empirical verification below.

Causal linkages between State-religion relations and religious community involvement should be traced from the historical position of religious communities in Southern European societies. As the most important service providers of highly-valued social goods, religious communities were in a strategic position during State-building, especially in socially homogeneous countries, to perform the role of key partners in policy formulation: healthcare and education, above all others, were nascent policy fields where their expertise and specific *ethos* clearly informed decision-making. In other words, institutional repertoires and frames of reference supporting policy-making in contemporary Western European States are by design sensitive to religious communities; while self-avowed secularist polities and secularization theorists (e.g. Bruce 1996, 2002; Wilson 2003) have underplayed the role of religious communities in the provision of public goods and their continued salience in civil society, in our three cases it is clear that religious communities have, to a large extent, integrated with public service provision, something which is clear in the health policy field.

It is also a consequence of the historical institutionalization of religion in healthcare, which paved the way to the current existence of several hundred religious organizations specifically geared towards the provision of healthcare at many levels (but not the general hospital level, as we will see). The role of religion in healthcare continues to be institutionalized after a revolutionary process which indicted the Roman Catholic Church for its affiliation with the

authoritarian polity; many Church-managed hospitals were then nationalized, but the legitimacy of religion (equated here with the Roman Catholic Church) was never contested. Where devolution occurred, it was a function of State power and status.

When religious assistance services are able to use their pooled social skill to achieve higher legitimacy, reputation and status, they are likely to be able to negotiate the biomedical settlement and seek better terms for the presence of religion in hospitals. But this requires coalition-building with sets of actors in the operating core of hospitals as well: biomedicine is dominant but is hardly conceivable as a totalitarian institution. Humanistic medicine and the promise of whole-person medical models, along with the growing recognition of healthcare services as providers of care in conjunction with disease-curing functions, opens organizational opportunity structures for action by religious assistance services.

CHAPTER 5: Introducing the cases

The study of religious assistance in Portuguese hospitals requires contextualization on the religious dynamics of Portuguese society. The approach adopted in this dissertation is field-theoretical. The religious field is the highest-level, broadest-scale field in this study: in SAF theoretical terms, it comprises a dominant settlement, incumbents, challengers, internal governance units and endogenous/exogenous pressures. For that purpose, I structure the description around the guidelines offered by field theory. I start by giving a historical account of the history of religion in contemporary Portugal.

Healthcare policy and the historical development of hospitals is consequential to the study of religious assistance. The development of healthcare in the 20th Century resulted in a specific pattern of organizing health provision and, incidentally, the place and function of religion in that process. In this chapter, the Portuguese case is described along these lines.

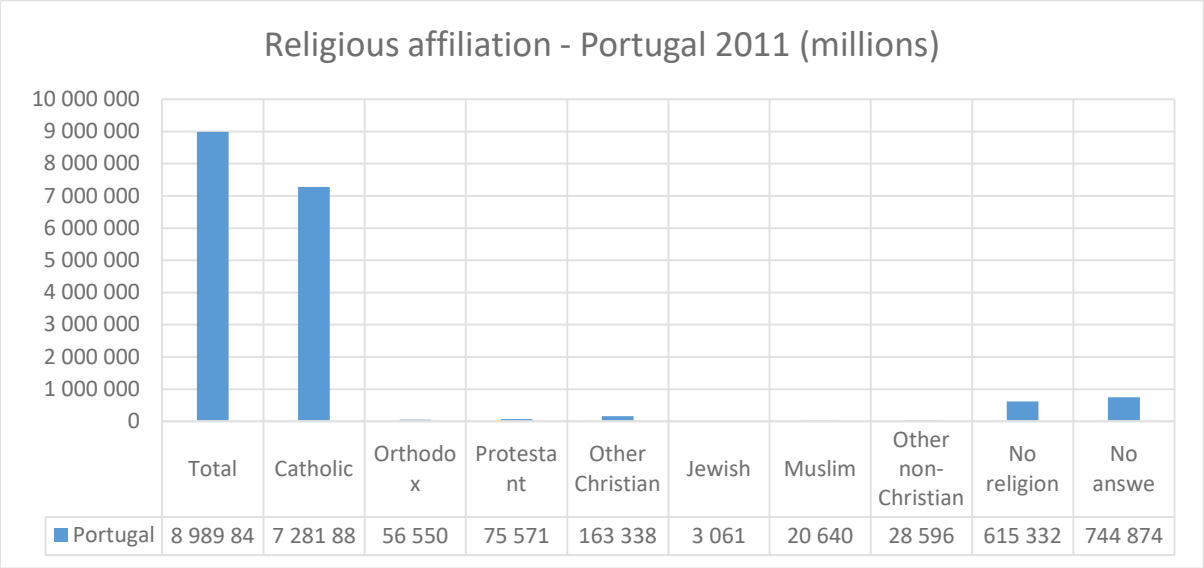
Because religion has been fundamentally contested in these settings, religious assistance and its regulation into Portuguese health policy is highly contested. Its regulation has struggled to deal with the emergence of religious diversity, on the one hand, and the perceived contentious character of religious actors in public healthcare venues. Religious assistance remains contested and, interestingly, its regulation in healthcare was more contested than similar processes in the military and the prison system. All three regulatory procedures occurred as a result of the 2001 Law on Religious Freedom, which enforced a transformation in the regulation of religion and in the State-religion relations arrangement. Because the 2001 Law enforced changes in terms of the recognition of religion and the exceptionality of Catholicism by the Portuguese State, the 1940 Concordat with its 1975 amendments required reconsideration. This is was the fundamental goal of parliamentary groups interested in enforcing a complete evacuation of religion from public institutions and organizations. In 2004, a new Concordat was signed in order to accommodate these broader legal changes. The legal transition was not complete, however. As it entered into force, the 2004 Concordat had to be made compatible with the new regulatory regime, which sought to displace Catholic exceptionality. Several provisions inherited from the 1940-1975 regulatory regime were no longer tenable under the terms of the amended Constitution, which continued to assert the non-confessionality of the State, and the 2001 legal bill, which mandated the regulation of the religious field by the State and the upholding of religious diversity in the form of official registration by accredited religious organization into a central Registry of Collective Religious

Persons ("Registo Central de Pessoas Colectivas Religiosas") and the institutionalization of a Commission on Religious Freedom where religious traditions were to hold seats and be consulted on matters of governance of religion. The religious field faced a period of reconfiguration in the wake of increased contestation over the dominant Roman Catholic-centered settlement and the meaning of religious diversity. However, increasing religious diversity did not make for a decrease in the intensity of Catholic dominance. Instead, religious diversity resulted in an increase of the overall power of the Catholic Church, which strove for allegiance with other, less demographically significant but symbolically relevant religious traditions. The resulting groups drove efforts to counter contestation over the place of religion in public venues. The inception of a Task Force on Religion and Health and the terms of the debate on specific issues, namely prayer spaces in hospitals and interfaith chaplaincy, resulted from a new settlement in the religious field which fed into health policy. The 2009 Regulation on Spirituality and Religious Care was an attempt to redefine religious assistance into a care-centered model which could have had the effect of countervailing the dominance of Catholic-led chaplaincy. Its initial draft was a clear attempt in that direction. It failed because the Roman Catholic Church was able to both structure a countering strategy against competing interests within the health policy system and a fraught but concrete front built within the religious field which encompassed most world-religion traditions (Masuzawa 2013) and kept challengers, both legitimate (such as the Evangelical Alliance) and illegitimate (such as new religious movements). Legitimacy derived from settlement terms in the Portuguese religious field. This is why no actors perceived as legitimate but challenging or illegitimate gained access to the Task Force on Religion and Health or to religious assistance services, but several legitimate, non-challenging actors gained access to the Task Force and part-time membership in high-end hospitals.

The religious field reconfiguration in 2009Traditionally, the Portuguese religious field is Christian-centric. In other words, Christian traditions enjoy higher status than other, non-Christian traditions. Roman Catholicism is perceived as dominant: it is demographically dominant and, perhaps most importantly, symbolically powerful. Figure 3 shows a statistical summary of self-reported religious affiliation in the 2011 General Census. 744 874 respondents chose not to answer, as the Census question on religion was optional. 615 332 reported no religion. Over 7 500 000 respondents reported Christian affiliation, which is indicative of the structure of the Portuguese religious field. The questionnaire structure is biased towards an overestimation of Christian affiliation: a number of studies suggest that, for example,

respondents who might have reported "Muslim" as an affiliation are severely underrepresented (Bernardo 2015; Tiesler 2005, 2011).

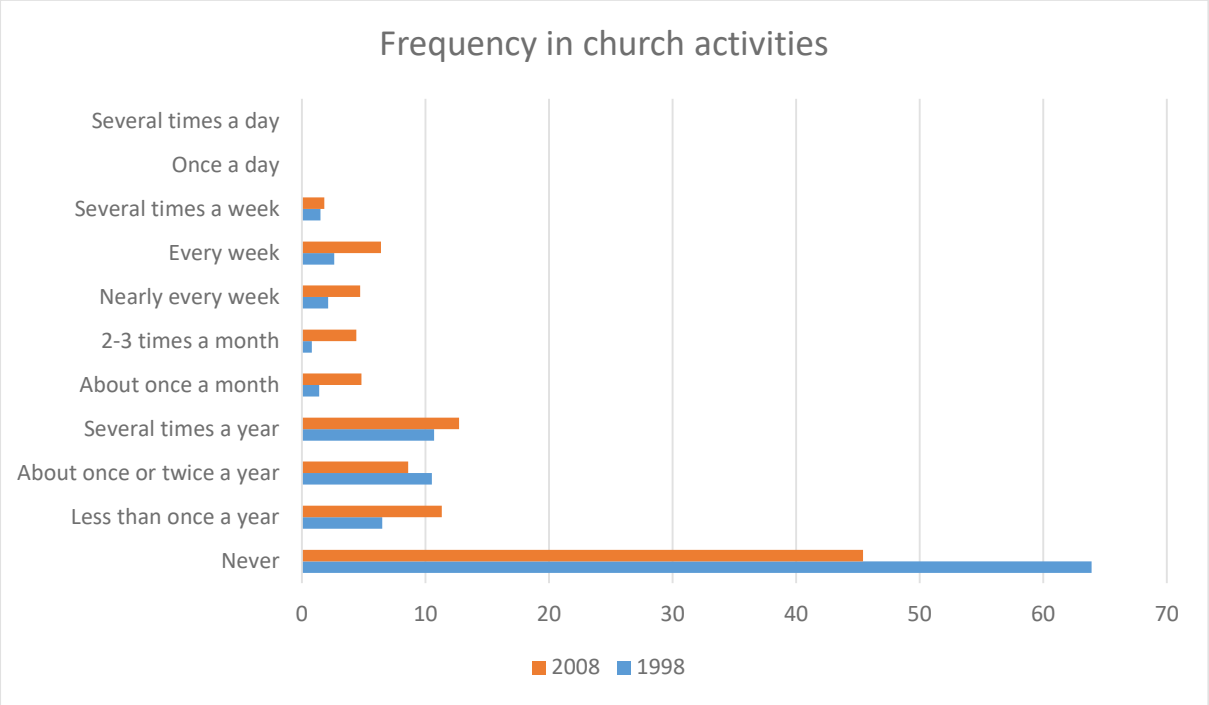
Figure 3. Religious affiliation in Portugal – 2011 Census Results



Source: Instituto Nacional de Estatística, 2011

Figure 5 shows reported frequency of church activities by Portuguese respondents to the International Social Survey Programme Waves on Religion (1998 and 2008). While reported affiliation is high, self-reported frequency to church activities is low, as more than 65% in either wave reports no or very limited church-related activity.

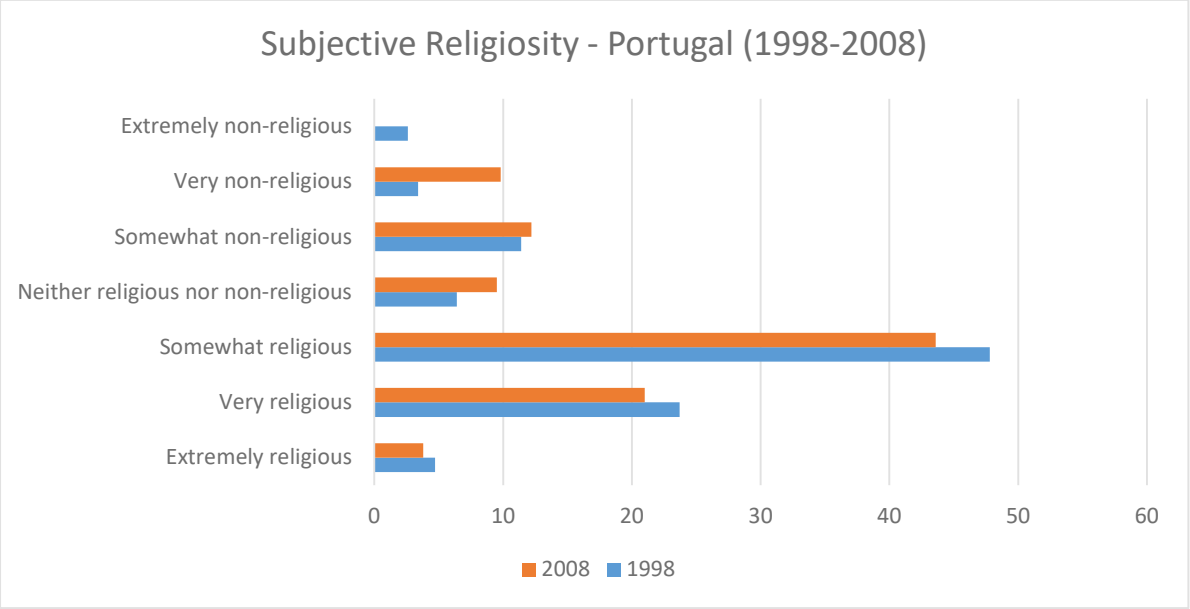
Figure 4. Frequency in church activities in Portugal, 1998-2008



Source: ISSP Cumulative File

Figure 6 shows subjective religiosity levels in Portugal between 1998 and 2008. Levels of religiosity show some contrast to reported activity in the context of organized churches: most respondents state moderate to high levels of religiosity. In this context, secularization has been reported as advancing slowly (Clemente and Ferreira 2003); as a comparison, Irish society, which shows a similar religious profile to its Portuguese counterpart, now reports very high levels of distrust towards organized religion and is trending strongly towards low levels of religiosity (Bernardo 2014). Portuguese society shows a religious profile which lies between advanced secular countries, such as Scandinavian cases, and monoconfessional cases such as Poland. In this sense, it is similar to Spain: urban settings show high levels of non-religion while rural settings maintain high levels of religiosity and trust towards organized religion.

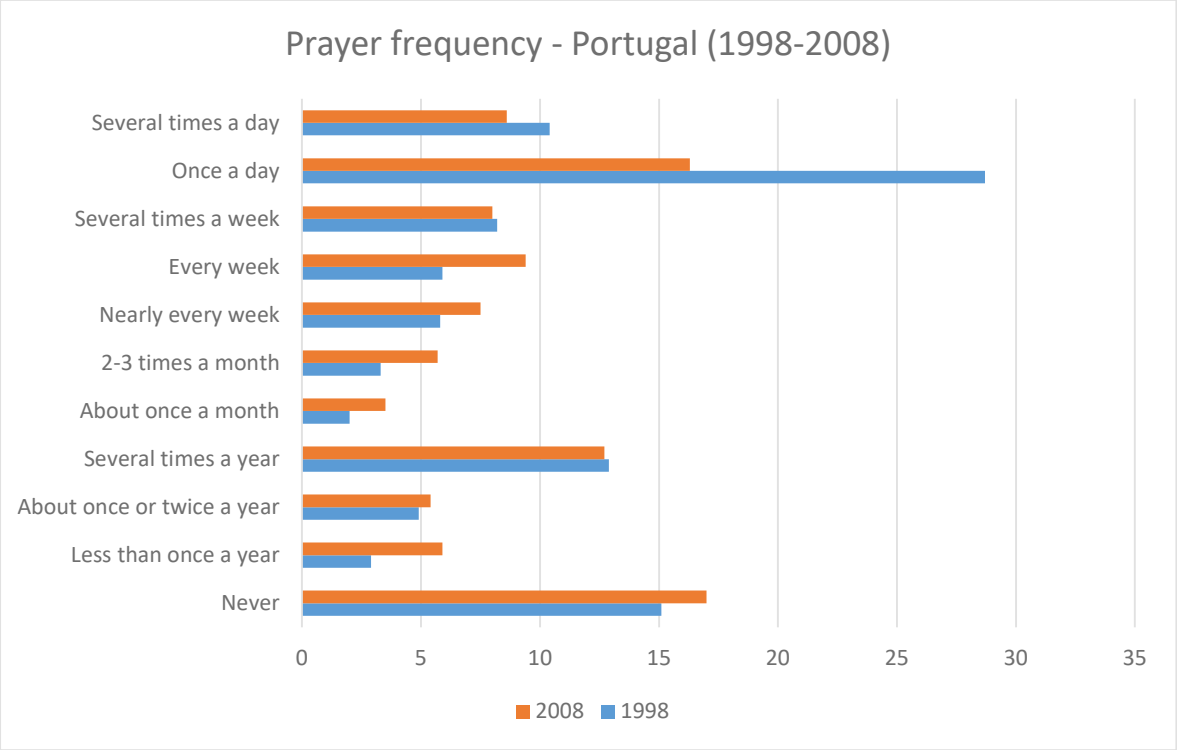
Figure 5. Subjective religiosity in Portugal, 1998-2008



Source: ISSP Cumulative File

Figure 7 shows levels of reported praying by Portuguese respondents between 1998 and 2008. The reduction of respondents who report praying once a day is notable, as is the increase in respondents who report praying less than once a year or never. This illustrates the changing dynamics of religious belief in Portugal immediately before and during the 2001-2010 period.

Figure 6. Prayer frequency in Portugal, 1998-2008



Source: ISSP Cumulative File

Other Christian traditions, such as congregational and non-congregational Protestants and Orthodox, are perceived as secondary allies in an ecumenical front within the religious field. The role of protestant churches and their pastors is particularly interesting in this regard. Because, as a subset, it is demographically relevant and historically significant – several of these traditions are labeled "historical churches" and enshrined in legal bills because of their longstanding role in Portuguese society, particularly in the provision of education. This is the case of the Methodist and Anglican churches. The case of non-"historical churches" proves more difficult to discern. While their status as Christian communities is undisputed, their demographic significance has proven to be an important argument against their diminished political status. The 2009 Regulation on Spirituality and Religious Care was disputed within the religious field by this subset. The Roman Catholic Church maintains some distance to this subset, as it perceives its challenging rhetoric to be politically motivated; conversely, it seeks compliance from "historical churches" as it perceives their non-challenging behavior as beneficial to the maintenance of the dominant settlement of the religious field. In all interviews done in the framework of this research with religious tradition representatives, the common theme of an ecumenical alliance was introduced by interviewees as a factor in the continued dominance of the Roman Catholic Church. All interviewees mentioned a centripetal dynamic

in the religious field which is not necessarily a function of political acumen or skill by Catholic representatives or the continued significance of the Catholic Church, but also a measured, calculated move by Christian churches which seek the leadership of the Catholic Church in politically sensitive topics, such as religious assistance in hospitals.

World-religion traditions are perceived as historically significant and hold globally significant stature and legitimacy. Islam, Judaism, Hinduism, Buddhism and Baha'ism, in Portugal, are particularly significant. Their significance is ascribed to their perceived historical stature in civilizational terms. While their demographic significance is of little consequence even in the context of migration regime transition, their resources surpass their direct potential significance. The example of the Ismaili Community is illustrative in this regard. Its political leverage is significantly higher than any simplistic reading of the religious statistics would suggest. The Aga Khan Foundation is one of the most significant civil society actors in Portugal and the 2010 agreement between the Portuguese State and the Aga Khan, which resulted in a quasi-concordat, illustrates the complexities of these relationships. Sunni Muslim representatives, particularly the Lisbon Islamic Community leaders, also benefit from exceptional clout and are traditionally committed to the maintenance of the *status quo*. The emergence of civilizational arguments against Islam, in the wake of international conflict and other events involving nominal religious actors, has done little to threaten the position of these actors; the standing of institutionalized Islam is not in question, even if the leadership status of historical figures within Muslim communities in Portugal is increasingly questioned by emerging local communities, centered around migrant communities, such as the Pakistani and Bangladeshi communities, which contest the dominance of traditional leadership and challenges its claims.

A set of less significant actors puts the Catholic-centered structure of the religious field in sharp focus. This set comprises actors perceived as illegitimate and which pursue challenging or accommodating strategies in the religious field. In other words, these actors may challenge the existing dominant settlement, which is the only observed strategic orientation, or they may pursue an accommodating stance, choosing not to question the existing *status quo*. Neopentecostal churches, which hold strong memberships in the Brazilian and Portuguese-speaking African migrant communities, are frequently posited as threats to the overall stability of the religious field and the stature of religion in the Portuguese public sphere. Jehovah's Witnesses are also in this set. Members of this set are doubly relevant to religious assistance in

hospitals. First, these groups are generally interested in healthcare-related issues. Charismatic churches, such as neopentecostal ones, make claims based on faith healing and other forms of religious practice which are denied by medical practitioners. These practices are defended by their practitioners on the basis of arguments of faith. Jehovah's Witnesses, on the other hand, make defensive claims on their right to deny blood transfusions not on the basis of arguments of faith but on the basis of peer-reviewed medical studies. The stance of Catholic chaplains is particularly interesting in this regard. As detailed below, chaplains deny legitimacy to this set of religious traditions on the basis of their reported behavior and sustain their positions on the basis of a lack of scientific evidence on faith healing. A common theme in all interviews with chaplains is their position as gatekeepers of hospitals against proselytizing agents, particularly neopentecostal representatives, who seek entrance into public hospitals, according to chaplains, in order to disturb patients and seek conversions by individuals in vulnerable situations. This is deemed unacceptable by chaplains. Interestingly, the same argument is used against Jehovah's Witnesses. Proselytizing is seen as the dominant strategy and as the foremost reason for exclusion from hospital space. It is a repetition of the more general argument provided by the Roman Catholic Church against legitimization tactics by members of this group. The argument is likely to have been coopted by the Portuguese State, as the 2001 Law on Religious Freedom points to exclusion clauses that define what a religious tradition is based on threat perceptions by the Roman Catholic Church.

As the internal governance unit in the religious field, the Portuguese State is able to define which religious traditions are eligible for representation at the Commission for Religious Freedom. In a strict sense, those religious traditions which are selected as members of the Commission take part in a form of corporatist representation which is co-defined with the Roman Catholic Church. The issue of registration in a religion-specific public registry according to specific criteria, which enforces hierarchies in the religious field by stating which religious traditions are officially recognized as such to the detriment of others, on the basis of historical establishment, is also evidence of corporatist selection in the religious field.. However, religious traditions' eligibility is also a function of how religious traditions in Portugal perceive themselves and their peers in the religious field. If the Roman Catholic Church finds a specific religious tradition to be ineligible, it is difficult for that tradition to become more legitimate and eventually take part in corporatist decision-making, namely through membership in the Commission of Religious Freedom. As Roman Catholicism remains dominant, both socially and politically, the structure of the religious field revolves

around the Roman Catholic Church as center of gravity. Debates on secularity and the decreasing political power of the Church, which continue to underline the aconfessionality of politics in Portugal, by pointing to constitutional clauses and other legal artifacts, point to the primacy of legal perspectives, as suggested in Chapter 4, over comparative historical studies.

Portuguese society has been perceived since 1990 to move towards pluralization and secularization. Growth in minority religious communities, especially Christian traditions, over the last 20 years, points to an ongoing reconfiguration at the outer edges of the religious field; the core remains Catholic, even if church attendance rates have declined (Freire 2001; Teixeira et al. 2012; Vilaça 2006, 2012, 2013; Vilaça e Oliveira 2013). The policy implications of this remain understudied. The influence of Catholicism, the Catholic Church, self-described Catholic politicians in the contemporary Portuguese policy process and, more specifically, in actual policy subsystems and venues, has also not been extensively studied: indeed, most studies tend to focus on both macro-level research, e.g. State-religion relations (Adragão 2002; Canas 2005; Manuel et al 2006; Wiarda 1998) and historical analyses of the relationship between fascism, the dictator Salazar, the State apparatus and Church hierarchies (Dix 2009, 2010; Gill 2008; Santos 2005; Reis 2006). Case studies on policy subsystems are generally limited to education and symbolic policy issues, namely socially divisive matters such as those mentioned above and including euthanasia or living wills. Although abortion and euthanasia are issues with important religious overtones and whole sets of political arguments derived from religious beliefs, the study of Portuguese religious dynamics is yet to broach the subject of domain-specific impacts by religion.

The Portuguese religious field is dominated by Roman Catholicism in its institutionalized and non-institutionalized forms. More than 75% of total population in Portugal reports “belonging” to the Roman Catholic community (following Davie’s terminology (Davie 2007)). The Church, as the embodied expression of community, exerts influence on many aspects of Portuguese social and political affairs. One of the main arguments in this dissertation is that Roman Catholicism and the Roman Catholic Church benefit from monopoly conditions in the religious field, affording both faith and institution an entrenched position in society and politics. Recently, two challenges to this monopoly emerged: an increasing and ongoing diversification of the religious field, as a result of migration transitions and a diversified pool of belief systems to which individuals may gain access with less effort than before (as argued by Charles Taylor (2007)). Brazilian and Cape-Verdean migrants brought new religious practices and ideas to the

fore. Secularization, as a process of relational reconfiguration between the religious and political spheres, made the fabric of the religious field an open question rather than a unquestioned assumption.

This is important for policy because it allows for a number of assumptions: if a single group expects a number of pre-allocated benefits in a monopoly situation, it will probably strive to keep the *status quo* in place, as the Catholic Church has done over the last four decades in Portugal, even in the difficult situation it has seen itself in and the complex politics it has faced; moreover, if it benefits from a monopoly situation, it lobbies the State to keep that monopoly (which is nothing more than a set of institutional arrangements that prevent resources from being redistributed in a field or system supported by stable power structures); if the group sees its monopoly credibly threatened (e.g. by historical trends or societal change) without possibility of recourse to active resistance against monopoly breakdown or actor suppression, it will seek coalitions, reframe the debate and reposition itself (e.g. Gill 1998, 2008; Gorski and Altinordu 2008, Kalyvas 1996; Warner 2000). Monopoly conditions explain the behavior of the Portuguese Roman Catholic Church in healthcare and especially in spiritual care, and should be tested in other policy contexts. Since 2009, it has increased its multi-faith dialogue efforts, as that year marked the ending point of a series of regulatory shocks to the religious field which started in 2001. The State gradually changed the regulatory regime. Initially, the Catholic Church sought no coalitions and acted upon its strengths as the largest civil society actor in Portugal, and lost many of the challenges it faced. The evolution of Church strategies and discourse, *vis-à-vis* healthcare, suggest that Catholic Church behavior has as much to do with State-religion institutional frameworks as with the structure of the Church itself, its representatives and the structure of the policy subsystem.

Portugal is generally perceived as one of the most homogeneous societies in Western/Southern Europe as regards ethnicity and religion. This extends from national identity to religious belonging and multiple longitudinal surveys seem to confirm this. Religion is conflated here with Roman Catholicism: in effect, Portugal and Poland, in strikingly different ways, are similar in the preeminence of a single religious tradition and its linkages to perceived national identity (Sobral: 2012; Trindade 2008). Further, the institutional history of the Roman Catholic Church, namely its territorial dispersion, its proselytization strategies and its relationship with the political sphere, frame much of Portuguese political history as late as 1974-1976 (Borges 2005; Carvalho 2013, Matos 2011). The contemporary Portuguese religious field revolves around this dual role of Roman Catholicism and the cumulative effects of its legacy. This is

the first axis on which the Portuguese religious field revolves. The position of Islam in the Portuguese religious field is illustrative: as a contemporary and newcoming actor, Islam has had to deal with Roman Catholicism as a cultural and political gatekeeper (Bernardo 2010). In this sense, contemporary Islam in Portugal has taken a specific shape partially as a result of challenges and questions posed by the State as well as Roman Catholicism and, to a lesser extent, by other religious traditions. This line of reasoning may be extended to virtually every other religious tradition in the Portuguese religious field.

The second axis we mentioned, Christian dominance and dynamics, derives from the simple demographic observation that the largest religious traditions in Portugal are Christian. Below, we discuss the impact of migration patterns on the religious field, which is observable especially in the increased number of Christian religious traditions. Here, we make two points. First, the Portuguese religious field is structurally biased towards Christian traditions both because of historical adaptation and their [Christian traditions] influence. We see this in the role played by numerous Protestant traditions and individuals throughout the 20th century, especially during the 1910s and from the 1980s on. While a complete study of religion and public policy in Portugal is yet to emerge, protestant traditions have clearly exerted influence in politics to a larger extent than other traditions; the emergence of non-traditional churches, from the 1980s on as both a result of the emergence of New Religious Movements (Vilaça 2006, 2012, 2013) and the above-mentioned transition in migration patterns (Mafra 2002; Vilaça 2013; Vilaça and Pace 2010), has further played upon this dynamic by inserting a modicum of conflict into a traditionally uneventful set of patterned relations (Vilaça 2006, 2012, 2013). Before the current ecumenical alliance in the religious field, the emergence of non-historic churches within the Christian sub-field seems to have stirred historic churches into more assertive action; the 1980 Act on the regulation of religious care in healthcare provoked a little-seen protest response by Protestant churches. The contemporary significance of all Protestant traditions, including those traditions labeled as “historical” (with a presence of over 60 years in Portugal) or “non-historical” (with a presence of less than 60 years in Portugal) according to the 2001 Law on Religious Freedom provision, Orthodox traditions and charismatic non-historical churches, which are mostly unrecognized under the terms of the 2001 Law, has increased, both demographically and, likely as a consequence of this, discursively. This entailed a competition over dominance in the Christian tradition section of the Portuguese religious field. It is an important secondary dynamic: “non-historical” traditions are generally less committed to maintaining the dominant settlement or to upholding the regime of exception enjoyed by the Roman Catholic Church, whereas historical Christian churches

and the various Orthodox traditions are strategically oriented towards the maintenance of the dominant settlement, as they perceive this as a favorable power structure for their purpose, since it supports a common goal by religious traditions in the face of increasing secularity. The 2009 Regulation on Religious and Spiritual Care faced some opposition by non-historical churches and was questioned at the Commission on Religious Freedom as unlawfully benefiting the Roman Catholic Church and, coincidentally, as reinforcing the dominant settlement.

Late-modern migration patterns and their effect on religious pluralization are the third axis we underline as key. Portuguese society has become a so-called "host" society only in the late 1990s, after a post-colonial peak in 1974-1976, as almost a million individuals entered the country following the onset of decolonization. While this peak is important in order to grasp the extent to which Portuguese institutions have had to deal with exogenous shocks, it is the case that migrant inflows became steadily incremental only after 1986, as the country became a member of then-EC and now EU and the Schengen area. Religious pluralization is linked to this. Migrant communities brought diverse belief systems into Portuguese society; although, as stated before, there was a historical degree of religious diversity, especially intra-Christian diversity and non-trivial Jewish and Muslim community presence, migrant inflow accentuated diversity to a level that pushed institutions to respond by adapting, on the one hand, and shaping communities, on the other hand. Both responses are significant to the analysis of Islam in Portugal, as discussed below.

Two salient features as regards migrant inflows into Portugal may be underlined: the size of Portuguese-speaking migrant communities and labor migration. The former pertains to the importance of Brazilian, Cape-Verdean and Guinea-Bissauan communities.

As regards the prevalence of Portuguese-speaking migrant communities, it is important to note that these communities show significant levels of nominal belonging and belief, if levels of subjective religiosity and church-going patterns in countries of origin are to be trusted. This is the case, for instance, regarding Brazil, which presents stable religiosity levels and increasingly plural patterns of belonging. Catholicism is becoming less and less significant and other Christian traditions, especially neopentecostal, are gaining ground. This is not to say that Protestant churches, evangelical and non-evangelical, do not weigh into the field, as they clearly do. Changes in these patterns and relations translate significantly into migrant community life as religious activities are not only individually relevant but make communities visible, wittingly or not, in the public sphere. Especially so in the case of neopentecostal churches, which put a high premium on aggressive proselytizing tactics. As stated above, these

churches have been important in redefining the Portuguese religious field because they not only bring different conceptions of religion, religious life, community ethics and organization into the fray but also generate responses from all other actors in the religious field. The Roman Catholic Church, in tandem with other religious actors, has pursued a stringent line of exclusion towards these perceived incoming challengers, something that has not happened regarding other Christian traditions and most non-Christian traditions. Shi'a and Sunni Islam are now traditional partners of the Roman Catholic Church in interfaith dialogue and institutional development; the real challengers, from the standpoint of several religious traditions, are these non-traditional churches. Many of these churches maintain close ties to the Brazilian diaspora and Brazilian pastors; to a lesser extent, this is also the case regarding other churches and migrant communities, namely Cape-Verdean or Mozambican. A standard and convincing answer to the aggressive response of the Roman Catholic Church and other religious traditions is the following: threat perceptions over the innovative strategies employed by these new organizational forms command action against them. A less instrumental view would state that normative differences over the role and behavior of religion and religious traditions in society, namely with regard to proselytizing and the usage of religious tropes to gain visibility is a more encompassing and convincing explanation: the Roman Catholic church and other more traditional religious traditions hold these new organizations in low regard for their uncompromising stance towards religious field occupation. None of this holds regarding Islam in Portugal, seen today as a non-threatening and sufficiently institutionalized tradition as to pose no significant threat to the stability of the religious field.

Other significant migrant communities pose different questions. East European migrants maintain ties to Orthodox churches, but these ties do not play out in the same fashion as those linking neopentecostal churches and Brazilian migrants. The question here pertains mostly to labor migration; however, this is also relevant to this study as labor migration has entailed the inflow of West African migrants, especially Guinea-Bissauan and Senegalese, and South Asian migrants, especially Indian, Pakistani and Bangladeshi. As EU funds flowed into Portugal, large public works projects and megaprojects took off, necessitating an increase in unskilled workforce and facilitated by the emergence of new mobility regimes; moreover, a real estate boom caused a rising need of the similarly skilled workers. The 1998 World Expo in Lisbon and the 2004 European Football Championship are cases in point: there is an observable rise in diversity in the aftermath of these events, adding further to the stable migrant inflow mentioned earlier.

By 2007, the 2004 Concordat was due for further regulatory additions. Both Roman Catholic officials and State representatives agreed on this, because the 2001 Law on Religious Freedom enforced several provisions which were not compatible with the entering into force of the 2004 Concordat. Where the 2001 bill was not aggressively anti-religious, as its initial draft in Parliament was characterized, it nonetheless forced a reconsideration of State-religion relations in Portugal. The 2004 Concordat was not compatible with the 2001 redefinition without further and deeper amendment. After the 2001 Law on Religious Freedom, the ruling framework, which included the 1940 Concordat with its 1975 amendment and the 1980 Regulation on Spiritual Care in Hospitals, was legally incoherent and, most importantly, it was widely recognized as no longer reflecting the needs of Portuguese society. It was no longer the monolithically Catholic bloc crystallized by the 1940 Concordat, the 1975 *détente* between the newly democratic polity, revolutionary forces and the Church or even the 1980 Regulation on Spiritual Care in Hospitals. As mentioned above, the dual pressure of secularization and pluralization connected with the emergence of parliament-seated secularist groups with enough clout to propose a Law on Religious Freedom created the conditions for the breakdown of the Catholic monopoly and the need to reform State-Church relations. After 2001, a Committee on Religious Freedom was created. This is a venue where State perceptions on which community by what standard is legitimate and deemed politically legible (Scott 1990; Laurence 2012) became clearer.

5.1 The 2009 Regulation on Spiritual and Religious Care

The following section results from original research. The 2009 Regulation on Spiritual and Religious Care is a relevant research starting point because it operates as a critical juncture. It opened up three trajectories which eventually became path-dependent. A close reading of its provisions and an analysis of its drafting shows that the aim of the regulatory arrangement was to produce convergence. This was a potential path-dependent trajectory. However, two others were possible. Divergence, as a result of interaction between centrally-defined and enforced regulatory standards and local orders, was a foreseeable result. Furthermore, it could also incentivize a transition from the traditional chaplaincy model to a Spiritual and Religious Assistance Service model – not in the terms defined by the regulatory standards, which sought to standardize rules of engagement and maintain illegitimate or non-accredited religious traditions outside hospitals, but in terms of the role of religion, its juxtaposition with

humanization and/or spirituality and the relationship between religion inside the hospital and outside its boundaries.

By 2009, it was clear that the monopoly of the Catholic Church on the usage of faith-related space and practice in hospitals was not adapted to current societal needs, especially in a context where intercultural practice was in the process of being mainstreamed into public service provision, following European Union-related convergence on shared values and anti-racist/anti-xenophobia policy. The emergence of culturally-sensitive public service provisions is related to this discursive shift, and both the State and the Church had to adapt. The process of draft and approval of Decree-Law 253/2009 was nevertheless surprisingly riven with contradictions and conflict; with the exception of Catholic and Seventh Day Adventist representatives, interviewees acknowledged conflict, but were surprised at the adamant position taken by the Church when the subject was broached. Indeed, there is evidence of conflict between the State and the Church in the process. While the State regarded a level playing field as a necessity arising from legal provisions and simple notions of distributive justice, the Church regarded such understandings and goals as colliding with both its continuing representativeness and the need to smoothen a transition into a plural regime as much as possible. The Church argued that, by dismantling the former regime, the State would not be aiding so-called "affirmative action" so much as disenfranchising that tradition which most Portuguese people held up as its own[2]; leveling the playing field should, again according to the Church, be about extending rights to all instead of eliminating them.

The Church representative in the process, also the Catholic chaplain at Hospital C and the national coordinator of the Health Pastoral Commission of the Portuguese Catholic Church, heavily criticized, as confirmed by interviews with religious representatives and news reports, the incumbent Health Minister and the State representative in charge of politically driving the process, the Health State Secretary. In the midst of an unexpectedly protracted process, the responsibility for drafting and approval of the Regulation was removed from the Health Department by the Prime-Minister, who took up the issue himself in an unexpected move, and changes were inserted into the draft Regulation; its final version is, according to one interviewee, more in tune with Church demands than the first draft, which aroused heavy

[2] The issue of size and representativeness was brought up by all interviewees and the need to recognize the Roman Catholic Church for its historical importance and societal representativeness was also asserted, with the significant exception of both Protestant representatives (Lusitanian Church and Evangelical Alliance), which discount such exceptions as politically motivated and thus invalid.

criticism by the Church. During my interviews, representatives apart from the Evangelical Alliance seemed oblivious to the process and the Roman Catholic Church expressed indifference towards the political underpinnings of the whole process. While the then-interim President of the Commission for Religious Freedom (a former president of the Evangelical Alliance) publicly expressed his reservations about perceived weaknesses in the final bill, other representatives preferred a more cautious approach, either refraining from making open statements on the document or abiding by the principle of representativeness and seemingly accepting Catholic oversight.

A reading of the 2009 Regulation on Spiritual and Religious Care reveals that there were three entities involved in the draft, writing and approval of the Regulation. First, the Portuguese Bishops' Conference; second, a peer committee composed of representatives of the Vatican and the Portuguese State, arranged under the Concordat; finally, the Commission for Religious Freedom, itself a regulatory agency where the Church holds representation according to its perceived significance[3]. The draft was written by staff at the Health Department, as requested by the Commission for Religious Freedom[4]. The initial draft was seen by policy officials as effecting little to no modifications on the existing framework. It was perceived to preserve the 1980 regulatory standards and the demands of the concordatarian regime of exceptionality accorded to the Roman Catholic Church. A second draft was requested, which was perceived to redefine the religious assistance framework to a larger extent. According to reports by interviewees[5], it sought to disestablish paid religious assistance and enforce a voluntary framework without permanent positions. It also defined religious assistance without recourse to the representativeness of specific religious traditions. The initial draft was seen as changing little to nothing at all, leading to a major revision; it was this second version that led to the above-mentioned controversy.

The final draft, leading to the official bill, was thus read and approved in sequence by a) the Bishops' Conference, b) a body directly resulting from the Concordat and c) the regulatory agency for the religious field. In an interview, the interim president of the regulatory agency

[3] Catholic members of the Commission for Religious Freedom include three members of the Bishops' Conference. According to the interim President of the Commission, one of the State-appointed representatives, who incidentally was one of the main drafters of the current Law on Religious Freedom, is also known to be a practicing Catholic.
[4] Interview, ínterim President of the Commission for Religious Freedom; Interview, former Health State Secretary.
[5] Interview, former Health Minister.

stated that the sequence as written into the final version occurred exactly as written, meaning that the Bishops' Conference was consulted during the drafting of a State-issued regulatory framework before the regulatory agency. The Commission for Religious Freedom had to protest delays from the other bodies in sending the draft it had initially requested. Interviews with representatives from other religious communities revealed these important data: knowledge of the process was limited and, when conveyed, informants were compelled to offer quiescent remarks. These remarks were justified with the seeming representativeness of the Catholic Church; no religious communities apart from those with actual representation in the Commission for Religious Freedom were actually consulted.

This indicates both the influence of a monopoly-seeking strategy and a policy legacy which supports certain institutional repertoires, namely the embedded preference accorded to the Catholic Church and the subsidiary character of other traditions, whose role in this institutional redeployment was secondary.

5.2 The Task Force on Religion and Health

The question of whether monopoly was actually broken must therefore remain open, as an interesting ongoing process takes us further into a discussion on the strategic behavior of the Catholic Church in Portugal. It relates to the aftermath of the 2009 Regulation and the arrangement of a Task Force on Religion and Health. Driven by the Catholic Church, the Task Force's its dynamics are connected to the Commission on Religious Freedom and previous efforts towards the allocation of public resources, namely broadcast quotas in public television. According to its members, this informal group intends to work in training, especially in cooperation with medical schools, and in the easing of access by chaplains and religious assistants to patients via so-called "informed consent" form sheets, a way of circumventing constitutional limitations to patient and patient information access by non-professional groups. Responses by hospital administrations in our observed cases has been mixed: Central and Northern are reported to have been open to innovation, while Southern remained cautious.

This task force, which works as a civil society-led forum (albeit with linkages to the Health Department), was first formed at the behest of Hospital C chaplain. The context of its formation is difficult to reconstruct, as informants provide contradictory accounts; however, all representatives agree on the centrality of the Catholic Church in the process. The Buddhist

representative compared the healthcare policy field to the much more contentious issue of public broadcast quotas, which have seemingly caused lively debates – according to the representative, precisely because actual allocation of quotas took place: "This [discussion by religious representatives on health] was nothing like that [broadcast quotas], it was completely peaceful and everyone was in agreement"[6]. In the health care sector, the focus on "patient-led", "holistic" spiritual care took the edge off actual policy contests.

By framing religion as part of a broader movement towards humanizing hospitals and medical practice which pays increased attention to patients as multidimensional (Cadge 2013), chaplains and religious representatives from traditions perceived as legitimate, namely through registration in the official registry, participation in the official internal governance unit for the religious field and through recognition by the Roman Catholic Church, position themselves as legitimate members of the medical community. This was the main goal of the establishment of a Task Force on Religion and Health. By doing this, obvious conflicts between religious beliefs and scientist beliefs are toned down, if never completely silenced, and the role of religion, spiritual assistants and prayer spaces becomes normalized in hospitals.

According to interviews, religious traditions were randomly selected into the Task Force. It is clear, from interviews with Catholic Chaplains, the Jewish community representative and the Buddhist representative, that those groups represented as over-proselytizing, namely Jehovah's Witnesses and neopentecostal churches associated with the Brazilian community, were tacitly excluded because they did not, according to these interviewees, respect patient privacy and there were reports which confirmed an unwillingness to respect these norms. This is perceived as a threat to the stance of most religious traditions and especially those religious representatives who emphasize religious and spiritual care as part of legitimate medical discourse.

The selection process was therefore highly informal and based on interpersonal linkages, but interviews reveal that a selection mechanism may have functioned, as contradictory accounts from four different interviews[7] have been noted. By looking at those groups that participated in posterior events and an initial publication, it is evident that religious traditions were chosen either because their historical legacies were understood to be "legitimate" in the face of "world

[6] Interview, Buddhist representative
[7] One Catholic Chaplain, one Seventh Day Adventist Pastor, the Baha'i representative and the Hindu representative.

religion" criteria (the Baha'i or the Hindu communities are examples of this), or because their policy relevance was itself a legacy (the Sunni Muslim and the Jewish communities). The influence of the 2001 Law on Religious Freedom, which enforces stringent conditions on the official recognition of religious traditions, is clear in this regard: New Religious Movements, as conceptualized by James Beckford (1985) or Eileen Barker (1982), are conspicuously absent – indeed, there is a remarkable isomorphism between the Commission on Religious Freedom and this Task Force, which is driven by Catholic efforts towards pooling resources and knowledge. Neopentecostal churches, at the core of major moral panics during the 1990s, are absent; Jehovah's Witnesses declined presence as of May 2012, taking a cautious approach to public engagement; rather more controversial movements, such as the Church of Scientology, are not recognized even as sects and the Church of Scientology has made the cover of a major weekly magazine under the guise of "very dangerous group". None of these groups are represented in official venues and policy is seemingly blind to their claims. Interestingly, all representatives from the Task Force seem aligned with the official position on non-recognition or non-assignment of legibility – as the 2001 Law enforces rules on recognition, these groups [constitutive of the Task Force] refuse the recognition procedure which would promote those outsider groups to eligible policy actors. The discursive device is clear: these groups, especially Jehovah's Witnesses and neopentecostal churches, take up a proselytizing tone which runs counter to the dominant understanding of hospitals, healthcare and patient-centered spiritual care; since arguments for the sustained importance of religion in medicalized settings rests almost entirely upon a hands-off approach to patients and full respect of constitutionally-protected personal space, threat perceptions against these groups engender resistance against their inclusion even into an informal forum. Indeed, proselytizing is seen to be embedded in the religious practice of certain groups, namely neopentecostal and Jehovah's Witnesses, and it has been offered as a reason for the voluntary non-participation in multi-faith events and processes. The few accounts available do not confirm or falsify these assumptions, as these groups are seen as assigning low priority to multi-faith relations. Interestingly, once questioned, informants remain adamant that acceptance into the Task Force is voluntary and open; NRMs remain ineligible, calling into question the overall pluralization of the field. Moreover, it is understood by interviewees, especially Protestant representatives, that coalition-seeking behavior by the Catholic Church is self-interested at least in that it seeks to counter the advance of secularism as it failed to stem secularization; far from unpredictable or unobserved in other contexts, it seems to play neatly into a strategy of monopoly maintenance and the underplay of competition via co-optation. In linking up all actors deemed as "legitimate" beyond official

venues, the Church is adapting to a transition in the topology of power in the religious field, which is in itself constitutive of State-Church relations. It offers support to all partners, either via access to key policymakers (the Task Force was able to meet the President of the Republic and garnered enough support as to launch at a large national event) or resources (it published a brochure, based on a similar leaflet from the Genève University Hospitals, with recommendations on identity-sensitive care, especially birth and deathbed-related practice). As recent data show, the number of practicing Portuguese Catholics is slowly decreasing, while Evangelicals, secularist/non-believing individuals and non-practicing/heterodox Catholics (i.e. those who believe to follow the precepts but prefer a more personal relationship to their God) are on the rise. In any case, the rhetoric of representativeness is still a major card in policymaking and public discourse on rights continues to be supported by the need to respect differences in representativeness.

5.3 The historical establishment and development of the Portuguese National Health Service (19th-20th Centuries)

In this section, I introduce the Portuguese Health Service and Portuguese hospitals.
First, I briefly describe the history of healthcare in Portugal and discuss the contemporary organization of healthcare as path-dependent. The dominance of the Roman Catholic Church in the supply of healthcare and medical knowledge is the most relevant topic for the purposes of this study.
Second, I describe hospitals in Portugal as historical entities in order to present an analysis of the contemporary organizational configuration of hospitals/hospital networks and their function within the Portuguese health service. The three cases used in this study are professional bureaucracies, reference hospitals, university hospitals and dominant hospitals. I discuss these categories in detail.

5.3.1 Religion in the historical development of Portuguese healthcare provision

In this section, I discuss the history of healthcare in Portugal. First, the religious history of healthcare, as the Roman Catholic Church was the foremost provider of healthcare in the country until the 19th century. Second, the monopoly on the training of medical staff was ascribed to the Roman Catholic Church until the mid-19th Century (Alves 2014). The first line of inquiry implies an analysis of the transition between religious and secular management of

healthcare; the second follows the same pathway. In this section, I show how religion is deeply connected to healthcare and medical knowledge in order to assess the current role of religion in healthcare.

Religious traditions in Portugal are commonly identified as social service providers, but the displacement of religion in hospitals has to do with historical legacies as well. Organized religion was the backbone of healthcare provision from the fall of the later Roman Empire, especially in Latin Christendom. Healthcare was provided in a context of non-secular care and most educational facilities were also dominated by a privileged class of clergy workers and intellectuals. With very few exceptions, medical practice was controlled by priests. As State-building processes started, sovereigns earmarked resources to health provision as a means to consolidate authority. This translated into a challenge to religious organizations, but the role of religion in caring and healing was never seriously questioned until the second half of the 19th century, when medicine began evolving into a scientific discipline with a clear empiricist epistemology. In Portugal, the groundwork for the emergence of modern medical practice and facilities lay in the 17th/18th centuries. Proto-modern care and facilities appeared, albeit as incipient practices and venues. In the wake of the 1755 earthquake in Lisbon, medical focus moved from palliative to emergency care and population health required a workforce and knowledge pools that far surpassed the ability of religious workers to meet demand.

The 20th and 21st are markedly different. Although a significant number of health facilities and services continue to be managed by the Roman Catholic Church[8], the backbone of health provision was largely appropriated by the State or commercial enterprises which eschew the managerial role of religious representatives. Instead, the institutional practices regarding religion suffered downward pressure as the politics of secularization translated into the imposition of a biomedical paradigm into healthcare.

5.4 The organization of Portuguese healthcare

Portuguese healthcare is organized along three axes: public monopoly, vertical integration and "hospitalocentrism". Public monopoly pertains to the core function of public institutions in the system: they are the backstops of acute care, specialist care and palliative care. Vertical integration pertains to the synergy between primary care and acute care, where local health

[8] The case of *Misericórdias* and Roman Catholic-related institutions is discussed in detail further in the chapter and throughout this study, as they provide important insights into the dynamics of religion, scientific medicine and health facilities.

clinics report to hospitals and low-end hospitals report to higher-end hospitals until the network core is reached. “Hospitalocentrism” refers to the core importance of hospitals in the system: hospitals absorb most financial and human resources and are the fundamental pillar of the system.

Healthcare in Portugal spins around two axes. First, a Beveridgean National Health System (SNS) which provides universal, mostly free health services to persons living in Portugal. The Portuguese Health Service is traditionally named Serviço Nacional de Saúde (National Health Service). For the purposes of this dissertation, SNS will be used as a label. Based on a 1971 (pre-democratic) Government ruling and structured by legal bills entering into force in 1979 and 1987, it is now a linchpin of Portuguese social policy. It is also, by far, one of the most demanding public systems, as far as personnel, infrastructure and discourse are concerned. Given the character of this study, all dimensions were considered throughout the research process; the third dimension, discourse, became more important as the interpretation of results went on. As a public institution, the SNS tends to comply with constitutional and legal provisions on the regulation of religion; however, the historical relationship between religion and healthcare, the complex character of healthcare institutions, as well as the specific character of individual experience in healthcare contexts, modulates compliance into a variegated and uneven phenomenon. Much as other public institutional contexts in which religion remains a relevant topic, such as prisons, enforcement of legal provisions in practice is not as straightforward as legal studies and scholars in Portugal tend to state while trying to assess the State-religion relations pattern. What this study shows is that the actual practice of regulation on religion in institutions is explained by variables other than macro-level ones. Because this study employs a most-similar systems design (Rihoux and Ragin 2009) which held and consolidated throughout the research process, results show that cross-case differences are not due to different regulatory environments, as State-religion relations apply – theoretically, at least – evenly to the whole universe of cases. In other words, hospitals do not define their own regulatory regime as regards religion; they must react and/or adapt to exogenous shocks. The universal, public character of the SNS enhances the impact of these shocks as hospitals, even when put in different typological categories, must adapt to a single regime. How they adapt and why they adapt in different fashions is the driving question. In that sense, this study strives to follow Wendy Cadge and Courtney Bender in their call for an analysis of actual institutional practice regarding religion (2013: 1-23). The Portuguese SNS is an interesting test case: it rose in a social and political context where secularity was legally enforced but questioned in

practice; moreover, as a universal provider of arguably the most important social good, its institutions must respect regulatory guidelines that pave the way to tensions regarding religion and the legitimacy of religious representatives. More precisely, hospitals must provide care while respecting legal guidelines which establish close to full equality while dealing with a religious field which was perfectly unequal until the 21st Century. Institutional realities in healthcare thus face a twofold challenge: how to reconcile religion and biomedical medicine, which does not assign legitimacy to non-scientific knowledge, and how to correct inequalities in the access of religious traditions to public healthcare facilities and healthcare policymaking. Second, a network which comprises a backbone of two very different institutions: local Health Centers (*Centros de Saúde*) and hospitals. Differences concern two dimensions. On the one hand, cross-institutional differences, as Health Centers are local organizations which provide primary care, are generally oriented towards preventive care and run low-budget, undifferentiated operations, meaning that nursing and non-specialist support personnel dominates institutional processes, whereas hospitals are the system backstop, as they provide acute and specialized care, are oriented towards patients and treatment care, and run high-budget, highly differentiated operations, meaning that physicians and management dominate institutional processes. On the other hand, intra-institutional differences, as Health Centers are heavily dependent on the size of their communities as regards which services are provided and are generally less demanding on public funding, while hospitals abide by a strict hierarchy and are financially autonomous but much more demanding on public funding, thereby establishing hospital categories which are useful for research purposes. The research process has shown that these features are important towards case selection, hence their detailing here.

Professional groups and, more recently, hospital management personnel are the two dominant groups in hospitals. This has important consequences as regards the place and role of religion within these institutions: as many professionals are educated in a strictly biomedical way, many remain distrustful of religion as part and parcel of human experience. Interviews with religious representatives, including Roman Catholic chaplains, replicate results from the few studies available; while an identifiable trend towards holistic, patient-centered medicine is emerging, the biomedical paradigm, which focuses on technology-heavy curative treatment, thus ignoring what non-medical personnel place at the center of human experience in hospitals, is still dominant. Nursing staff and physicians do not generally afford an equal footing to religious representatives. As hospitals became public enterprises, in the early years of the 21st Century, their role in the SNS also changed. The sharing of health production with patients and patient

communities forced a reevaluation of biomedical assumptions, which again displaced religion from a growingly marginal place and role to a recentered one.

Religion was placed into a secondary role both by dominant social frames and by the interests of health personnel, who sought to enlarge their roles and authority within institutions by increasing their autonomy *vis-à-vis* political priorities and religious priorities. In practice, chaplains in hospitals lost much of their capacity to influence care provision. The emergence of patient-centered care and a World Health Organization-endorsed paradigmatic transition into holistic treatment, as "care to the whole human being", afforded a window of opportunity that religious traditions sought to play upon, commonly through reframing strategies which refocused religion as one of the most important components of human experience and, significantly, as a component which does not question the basic tenets of scientific medicine. Underlining the importance of humanization in health care, the spiritual component of human experience as a universal category and participating in ethics committees along professionals are the three strategies employed by religious representatives when questioned about the role of religion in healthcare. Science-based medical treatment is never disputed by these individuals as the foremost responsibility of healthcare. On the contrary, medical treatment is regarded as enhanced by spiritual and religious assistance. One interviewee for this study stated that "[spiritual and religious assistants] need to focus on the full human being, not just the religious aspect, but also the bio-psycho-social dimension" and, importantly, that "we [spiritual and religious assistants] must adapt to the culture of hospitals, not the other way around"[9].

The underlying tension between questioning the capacity of professionals to provide spiritual care and the recognition of professional authority is never fully explored as, it is argued here, the window of opportunity previously mentioned would turn into a gauntlet: religious representatives in healthcare facilities recognize the precarious character of their institutional role and the centrifuge trend, interpreted as stemming from secularizing tendencies in Portuguese society, towards an evacuation of religion from healthcare. Although an analysis of institutional arrangements shows a trend towards stability in the role of religion in healthcare, this is an important narrative device both because it is shared by professionals and religious representatives and because it stops religion from being actually evacuated or run the risk of being ignored by professionals. As a conclusion, religious representatives adopt what may be conceived as a post-modern ethics of care, both in their concept of religion and in their role as carers within the hospital environment.

[9] Interview, Roman Catholic Church Health Pastoral Representative.

All representatives interviewed for this study emphasized the need to humanize facilities, especially larger, more technically-oriented organizations such as hospitals with many wards and many thousands of inbound patients under care each month. Thus, religion becomes a source of palliative care, following the requirements religious representatives must observe if they are to take advantage of the window of opportunity without further exploring latent tensions between themselves and professionals. As such, religion has maintained, if not quite recovered, much of its appeal in a policy setting which has been contentious enough over the last 200 years to garner a significant place in almost all political transitions over that period; healthcare is probably the most contentious and understudied policy subsystem in Portugal, especially in what concerns the tenets of health systems research. This is further complicated by the need to cross health systems research, an analysis of regulatory impacts on complex organizations (both hospitals and religious traditions), a structural analysis of the religious field and, to be more specific, an analysis of monopoly conditions in that religious field. For a number of reasons (Cadge 2009) the contentiousness of the broader topic spills over to the apparently non-contentious issue of spiritual care in hospitals and illustrates how the Catholic

Church is able to activate its agenda control capacities and to "mobilize bias", in the words of Schattschneider (1960), to include or exclude, with varying degrees of State interference, religious communities in policymaking and regulation. These two intertwined topics are discussed elsewhere in this study as key components of the structure of the religious field. As is shown throughout the study, monopoly conditions are neither a deterministic outcome of State regulation nor a function of Roman Catholic sociological representativeness; being politically and socially constructed, other religious traditions seek to improve their position within Roman Catholic monopoly. Throughout the study, strategies towards that goal were seen in the context of spiritual care in hospitals.

5.5 Modern hospitals in Portugal: structural change and performance orientation

In this section, I outline the development of Portuguese hospitals into their current configuration and function. I pursue this analysis with the objective of illustrating how an initial condition, that of dominance of healthcare management by religious organizations, was transformed into State monopoly. The 19th and 20th century are especially relevant. It was in

these two centuries that modern hospitals came into being, with their professional division of labor and their organizational configuration around medical power. It was also in these centuries that religion as a social institution had to negotiate through its evacuation from a management role into a care role. However, it never became fully extinct in hospital settings. Religious assistance regimes became more prominent as a result of compensation strategies by groups of doctors, nurses and managers who perceived religion as an important aspect of patient lives and never embraced a fully non-religious outlook on medicine and illness. These groups are coextensive to the emergence of modern hospitals in Portugal: as these organizations became the main health providers in the country, the role of religion in public life remained fundamental. As a consequence, institutionalized groups of doctors, nurses and managers, at the time of inception of hospital organizations, were not yet committed to biomedical practice. Today, an important association of Catholic physicians and nurses remains invested in maintaining a connection between their practice and religious care. These caveats need to be contextualized within a particular feature of hospitals: they are symbols of State power and scientist knowledge, and both of these have emerged against religion. After religious management ended as a dominant regime, hospitals entered into a process of increasing professional managerialization. However, managerialization was not consequential to religious assistance regimes. This assertion is key to this study, as it sheds light into the emergence and process of religious assistance regimes in hospitals where, at least as regards management processes, managerialism came to question medical power and displace it. Religious assistance remained unscathed from this partial paradigm shift.

The function and configuration of contemporary hospitals in Portugal In this section, I discuss the contemporary configuration and function of hospitals in the Portuguese health system and society, as it emerged from the previous section. Hospitals are complex organizations and religious assistance regimes add to that complexity because they are not easily placed into the organizational division of labor and they do not seem to react to changes in the regulatory framework of hospitals. The central role of hospitals in the Portuguese health system and as a symbol of State power are discussed in this section.

All Portuguese hospitals share the same basic organizational structure. Heading the organization, a Management Board oversees hospital operations and manages the budget. Its members include a board president, at least two executive directors, the physician director for clinical services, the nurse director for nursing services and a rapporteur. The Clinical Board oversees healthcare itself. These Boards are supported by a number of committees, which may be established according to internal guidelines, but generally abide by two functional axes:

technical and non-technical support. Technical support concerns clinical-related operations, while non-technical support concerns hospital operation and patient wellbeing. Generally, religious assistance is included in non-technical support. All hospitals include oversight mechanisms for budget review, patient welfare and quality control.

As recent organizational developments in Portuguese healthcare – traditionally centered on private, smaller organizations, but parallel in development in the Serviço Nacional de Saúde (SNS), hospitals became its key components in less than half a century. The SNS is usually described as "hospital-centric" (Barros et al. 2011) and recent criticism over dependence on hospital care has driven change towards primary and preventive care. Mergers between hospitals, justified on the grounds of efficiency and cost-reducing requirements, have shifted the centre of gravity of the SNS towards local facilities, namely UCCs (Continued Care Units – Unidades de Cuidados Continuados) and USFs (Family Health Units – Unidades de Saúde Familiar), turning hospitals into high-end system backstops, in the sense that only acute or specialist care should be provided by hospital personnel. Hospital Groups (Centros Hospitalares), as larger groupings of former autonomous hospitals are now called, also mark a shift towards managerialism. While seemingly unimportant to spiritual care in hospitals, this shift is also related to wider changes in the role of users and the social determinants of health, where religion, as part and parcel of users' identities, is seen as important in improving health outcomes and empowering citizens, as public facilities should attend primarily to the needs of users and the importance of efficiency and equity in healthcare. Thus, spiritual facilities within hospitals are seen not as remembrance of things past but as important to integrated care to the extent that integrated/holistic care is a modern take on the human being in medical settings.

In 2014, the number of hospitals in Portugal totaled 226; of those, 104 were public institutions. Hospitals are ranked by category, running from A1 to B2 and a higher-level division into Groups I, II and III. Importantly, A1 hospitals are not only larger institutions, they are also arguably different organizations altogether. Hospital budgets in 2009 averaged close to €37 million, while A1 hospitals all remain over the €150 million mark. Staff-wise, A1 hospitals also far surpass other hospitals: four of the six A1 hospitals employ more than 1000 physicians across all major Therapeutic Groups and 4500 total staff. Cost structures in these hospitals' budgets reflect their position in the wider hospital universe: they are cutting edge facilities which face pressures from several sides: from the Health Ministry, which stringently surveys expenditure and productivity/patient outflow ratios, from patients, who expect cutting-edge care at near-to-zero cost, from private hospitals, which seek to play upon insufficiencies and drive patients out of public care, and from other public hospitals which lack the installed

capacity and skillsets necessary to deal with patient inflows. These hospitals are public enterprises and managed by professional staff, further layering any research process. Moreover, contests over knowledge and legitimacy in very complex institutions, such as hospitals, are enhanced by exogenous as well as endogenous shocks. When nursing staff, physicians, support personnel and religious representatives need to face hospital administrations in order to advance their interests, power dynamics and self-interested strategies ensue. This is framed around the general perception of the hospital, especially high-end ones, as imperfect epistemic communities: value systems are shared but also give way to contests over legitimacy and dominance, thus placing religious representatives in less than certain positions as regards their goals.

In this study, as Portuguese hospitals are embedded in a single social and regulatory environment but enjoy different capacities and capabilities, we propose to conceptualize the hospital network as a learning community and engage in an analysis of diffusion and learning. Some hospitals share the same amount of resources and capabilities, yet they adapt in different ways to regulatory shocks. The regulation of religion in hospitals is no different from the adoption of accountancy standards, medication restrictions or cutting-edge therapeutics if we see them as instances of regulatory shocks which these hospitals may not respond to by ignoring them or abandoning the sector. They are, in other words, non-optional and hospitals do not have the right to demand opt-out clauses. They must adapt within a regulatory environment and deal with a very complex bureaucratic and power structure within, where groups and individuals may not fully concur with regulatory impositions.

Each selected case is, as reported in the introduction and case selection chapters of this dissertation, more similar to other members in its category than to any other healthcare facility. Furthermore, each of these cases is a university hospital and there are six medical colleges in Portugal. This is an important issue as regards religious assistance: university hospitals, as mentioned by Cadge (2013) and Carapinheiro (1993), have different power profiles and structures than non-university high-end hospitals. This is because teaching functions accrue on specialist knowledge to create pockets of power within the organization. For example, because neurosurgeons are rare, they are sought both as teachers and practitioners, which entails an accrual in prestige and status within the hospital. As mentioned above, specialized care tends to be less open to religious assistance because, as care and practice, religious assistance is linked to humanistic medicine and less specialized practice. Chaplains in each of the cases

researched for this dissertation reported difficult relations to medical specialties which rely heavily on technical expertise and are cure-oriented, while relations to medical specialties based on relationships and support, such as psychiatry and internal medicine, are more open and supportive to religious assistance services. This was a common theme in interviews. Because of this, it became apparent that humanization services are proxies of hospital environments conducive to embedded religious assistance. This is the case in Hospital C. It is somewhat the case in Hospital B. It is not the case in Hospital A, where, as part of research, it was found that humanization services did not exist *per se* and, where it was identified, it was seen as pertaining to logistics. The choice of university hospitals is thus relevant to this dissertation because university hospitals comprise a relevant subset of Portuguese high-end hospitals which share more similarities amongst one another than with any other high-end hospital. Furthermore, religious assistance in these instances was found to be provided by better-educated representatives than in other, lower-ranked hospitals across the country. These hospitals are located in large urban areas where religious diversity is higher than in other regions in Portugal. As university hospitals, these organizations are also attractive to a large international student community. There is increased pressure for adaptation to diversity and religious assistance is part of that process.

5.6 Conclusion

In this chapter, we introduced the Portuguese religious field and the healthcare system. Details on the 2009 Regulation in Spiritual and Religious Care are provided and a discussion on the Task Force on Religion and Health suggests that State-religion relations have changed to some extent since 2009 and to a large extent since 2001. In the next chapter, the effects of State-religion relation changes on religious assistance in each of the three hospitals chosen for this dissertation are discussed.

This chapter also introduced an important theme in this dissertation: the dominance of Roman Catholicism as the fundamental core of the dominant settlement in the religious field and the importance of the Roman Catholic Church as the most important interest group in the nexus between the religious and the healthcare policy fields. The Portuguese healthcare system is partially a result of the provision of services by Catholic organizations and the structuring of those services according to a specific *ethos*. Modern medicine and hospital organization disenfranchised Catholic dominance, which now remains confined to religious assistance and seeks to influence religious assistance policy, as it clearly did in 2008-2009, and group religious

traditions under its leadership in order to present a unified front against what religious representatives perceive as secularizing interests within the Portuguese State.

CHAPTER 6: Cases

6.1 Introduction

Power struggles have shaped the relationship between patients seeking religious care and religious communities willing and able to provide religious care. The number of Roman Catholic chaplains and chapels in public hospitals illustrates the dominance of the Catholic Church, but this is evident in more than legacies or symbolic monopolies. Until 2009, the allocation of this specific resource – spiritual care in public hospital facilities – was mediated entirely by Roman Catholic clergy. The role of the Roman Catholic Church as a gatekeeper is underlined by this: until the 2009 approval of the Spiritual and Religious Care Regulation (Regulamento de Assistência Espiritual e Religiosa), Catholic chaplains were *de facto* religious gatekeepers of hospital space. These officials held the power to decide which religious representatives entered hospital premises with the purpose of providing religious care[10]. This happened for two reasons. Because hospital visitors needed to be accredited at reception desks and religious traditions were not accredited as such by the State before 2004, religious representatives seeking entrance into hospital wards needed to ask for chaplaincy assistance in order to overcome bureaucratic hurdles. The 1980 regulatory framework stated that Catholic chaplains were hospital personnel and fully paid by the State. They should facilitate other traditions, but there were no specific provisions for the pluralization of hospital space or an official policy on the entrance of non-Roman Catholic representatives into wards. A Evangelical Alliance representative stated in interview that "in those times [the 1980s], we had to go to desks and request the presence of some Catholic priest (…), either that or we pretended to be Catholic priests ourselves, then desk workers would sometimes allow entrance"[11]. A Methodist representative reported a number of situations where "I had to put on a collar, you know, just like a Catholic priest, and then the security guard would let me in. He would tell me "Please, Father, go in". Otherwise, I would have to call for the head chaplain, who would have to come to the door and ask the guard to let me in"[12].

This was often seen as a discouraging sign of regulatory exception accorded to the Roman Catholic Church. In 2014, most public hospitals continue to provide a single Roman Catholic chapel and an office to one or more Catholic chaplains. While these institutional imbalances remain largely unattended, the regulatory regime has changed significantly and has had

[10] As confirmed in all interviews with non-Catholic religious representatives.
[11] Interview with Evangelical Alliance president.
[12] Interview with Methodist representative.

unintended consequences. In this context, it is significant that all religious assistance services in the three cases studied for this dissertation are no longer formally referred to as "chaplaincies", but as SAER – Serviço de Assistência Espiritual e Religiosa. Henceforth, these will be referred to as SRAS – Spiritual and Religious Assistance Service. While much of the work of its members is still self-perceived as religious, its description suggests a broader concern for spiritual solace and a general concern for spiritual care. Members of SRAS in each of the cases described below offer religious assistance but also come to terms with the spiritual implications of their work.

According to the Hospital A head chaplain, regulatory demands stand between spiritual assistance and patients: "I sometimes wish that this country would become more like the United States of America (…), they have a hands-off approach there, they don't interfere. We [religious representatives] sort thing out on our own and they [regulators and hospital management] are just meddlers"[13]. This is confirmed by the Protestant Alliance representative, who stated in interview that "now, even Catholic have trouble reaching patients. Before, they helped us, even if sometimes they didn't do what they should have done. Now, we're all on the same boat"[14]. These perceptions indicate that, at least as regards Hospital A, the pluralization advocated by the 2009 regulatory regime has had unpredicted consequences. It has allowed for other religious traditions to seek entrance into hospitals and, in the words of chaplains and, interestingly, non-Catholic representatives, attempt to proselytize. According to the Hospital B head chaplain, "nowadays, I spend a lot of time asking people from those groups to leave hospital premises. Security staff and nurses call my attention to them and seem to think that I am the one in charge of some sort of "religious security" in the hospital. This didn't happen as often before 2009. We [Roman Catholic chaplains] must look out for the sacred space of hospitals and the tranquility of patients. We are not in the business of converting anyone and those people [proselytizing groups] come here to disturb suffering people who need solace, not conversion"[15]. The interviewee also reported that, while the 2009 Regulation seems to have had some impact, he is unable to discern its precise character. In his view, "the State is not very helpful in sorting out these problems. It is up to us, as chaplains, to organize religious assistance and provide spiritual assistance to patients who ask us for company and presence"[16]. The

[13] Interview with chaplain, Hospital A University Hospital.
[14] Interview with Evangelical Alliance president.
[15] Interview with chaplain, Hospital B University Hospital.
[16] Id.

representativeness of religious traditions has very little to do with the actual workings of religious assistance and the reconfiguration of religious assistance service rosters: as detailed below, the SRAS at Hospital B had started its process of transformation into a multifaith service before 2009.

Interviewees assert that constructs such as "State-Church relations" or even "confessional representativeness" are of little consequence in the daily operation of belief within hospitals. These remarks do not mean that "State-Church relations" or "confessional representativeness" are meaningless. Instead, it is argued in this dissertation that confessional representativeness is one of the institutional underpinnings of religious assistance services in cases where religious diversity is not seen as a resource. This applies to two of the three cases studied for this dissertation. The structure of spiritual care in Portugal and the gatekeeping role of Catholic chaplains shows that macro-level variables exert an impact, even if indirect, on institutional life. But these are interesting statements because they contradict theoretical perspectives which underline the relevance of State-religion relations to instances of religion in public institutions and organizations. These statements also misrepresent or underestimate centrally enforced regulatory change in religious assistance patterns. Access to patients, according to chaplains, religious representatives from those traditions who are seen as legitimate and policy officials is much more related to relationships with hospital administrations. Observation within hospital premises and fieldwork in two training courses on spiritual care confirm that this is a dominant opinion. At one of those training courses, a discussion arose on the politics of religious assistance in healthcare. It was led by senior Roman Catholic representatives who voiced their concern over other interest groups exerting dominance in hospital administration decision-making. In interviews with former policy officials, these concerns were voiced by one interviewee who demanded that voice recording be shut down; the interviewee proceeded to describe the 2009 Regulation drafting process as riddled with inconsistencies and resistance at various levels. This description included reports of how the initial draft, as mentioned before in this dissertation, was intended to evacuate religion from hospitals and led to high-profile lobbying by the Roman Catholic Church in order to redraft it. The end result, as written into law, resulted from policy entrepreneurship and conflict which, as reported by the interviewee, trickles down from health policy into hospital administrations. These reports stand in contrast to two other interviews, where two high-level Roman Catholic representatives provided different opinions on the dominance of interest groups in healthcare which seem interested in evacuating religion from healthcare as a tactical move to break Roman Catholic monopoly. In discussing chaplaincy at Hospital A, one of these representatives mentioned that "it may be

that the current chaplain is a bit less trained in politics or perhaps a little less capable of making himself heard, but I have no doubt that the hospital itself is not neutral towards religion. They [hospital administration] may say so, but we [the Roman Catholic Church] know, I know, because I have been working many years in this field, that there people who resist religion in hospitals on the basis on undisclosed interests"[17]. On the other hand, another high-level representative remained doubtful. As an ordained priest in charge of a wealthy parish, a well-regarded voice in the Roman Catholic community and a highly respected physician, this interviewee stated that "the problem is that chaplains are too old-school (sic), most of the time they are older individuals who are uninterested in patient-centered support and their main interest lies in providing sacraments to people who are dying. I know that some hospital administrations do not trust chaplains, but this does not tell me very much. There are cases in which hospital administrations regard chaplains very highly and most of the time these chaplains are those who want to be as close to suffering people as possible, they don't care for religious speak apart from the essentially Christian ministry of presence and solace. So I suppose that all of those conspiracy theories may have some truth to them, but I mostly tend to ignore them. They are not useful for chaplains"[18]. These differing perspectives show a common theme: the political sensitivity of religious assistance in healthcare, which seems to be higher than that of religious assistance in the military or the prison system. It also shows how organizational experience and lived religion in hospitals – the religious assistance regime – determines religious assistance service. In the following sections, each hospital is described. Then, religious assistance service is analyzed in relation to specific staffing patterns which detail how the internal structure of each hospital determines opportunities for engagement by religious assistance service members. After each case is described, a comparative analysis of cases is provided in order to contextualize each of them. A transitional model of chaplaincy to Spiritual and Religious Assistance Service is proposed. Finally, the policy process of the Regulation on Spiritual and Religious Care in Hospitals is detailed in order to show how each case related to regulatory change. The option for describing the policy process at the end relates to the different levels of involvement of actors working in each case in the wider policy decision.

[17] Interview, former Coordinator of Catholic Health Pastoral.
[18] Interview, former Coordinator of Catholic Health Pastoral.

6.2 Chaplaincy and Spiritual Religious Assistance Services in three Portuguese hospitals

6.2.1 Hospital A

Hospital A is the second largest hospital in the country as regards physical space. Its target demographic comprises a densely populated urban area and most regions to its south. Its direct target population surpasses one million individuals and its position as a reference hospital for high-end treatment from other, lower-ranked hospitals assures its indirect target population surpasses three to four million individuals. As a Group E general Hospital B hospital, it lodges every major medical specialty and is able to treat all common acute conditions.

Originally conceived in the first quarter of the 20th century, it was built six years after the initial project was presented. Hospital A acquired its modern designation ten years after it was built, as a result of healthcare reform and the development of medical sciences in Portugal. It was seen, at the time, as a pinnacle of progress by the authoritarian government then in office. Throughout the 1970s and 1980s, the hospital adapted to a changing regulatory regime, as the Portuguese transition to democracy entailed a full transition from the organizational structures of autocratic rule to democratic rule; payment systems, promotion schemes and, importantly, the role of religion in the hospital changed. Today, it holds an Ethics Committee, in which one of the Roman Catholic chaplains holds a seat, and a Humanization Committee, signaling a paradigm shift from the biomedical to a holistic, integrated perspective. It is located within a large University *campus* and lodges a College of Medicine. The College operates a bioethics research center and offers an MA degree in Bioethics. The research center and the MA degree do not assign a specific or exceptional character to religious belief nor do their *curricula* explicitly recognize religion as a source for bioethical reflection and research.

Its prayer space is a chapel, which takes up an entire hall in a floor, and is operated by four individuals: three ordained priests and a hospital assistant. One of them is the head chaplain. Mass is held every Sunday. The service provides care for patients who ask for it, as enforced by law: it is mandatory to state, upon arrival, whether the patient wishes for religious support. The relationship between hospital managers and chaplains is tense, according to a chaplain: "(…) up there [hospital administration] they pretend we're not here and simply tolerate our presence with reluctance (…)", while the relationship between staff and chaplains is rather more relaxed, according to the same interviewee: "Nurses and physicians respect us because

they recognize that people are more than just patients, they are human beings who suffer and we [the Roman Catholic Chaplaincy] can provide some solace in difficult situations"[19]. There is no clear indication regarding multi-faith services, facilities or non-Catholic/non-Christian care within premises, but evidence suggests that the hospital seeks to become more culturally aware, as indicated by the formal establishment of a Humanization committee.

6.2.1.1 Staff structure and relations with religious assistance

Table 1 shows staff structure in Hospital A as of 2014. As expected, Hospital A shows higher than national and regional averages in all available categories. Table 2 shows reported specialty physicians in selected categories, namely internal medicine, family and general medicine and psychiatry. These categories are reported on the basis of their relevance to religious assistance. Physicians in those specialties are those most reported by religious assistance staff members as open to religion in hospitals: internists were mentioned by each SRAS member as open to the insights of chaplains and religion because of their focus on holistic medicine; family and general practitioners are reported as those most open to the insights of religion and religious representatives in hospitals as they recognize the value of spiritual and religious wellbeing; and psychiatrists, given their focus on relational practice and mental health, engage with chaplains to a larger extent than any other medical specialty. Furthermore, SRAS members report usage of techniques first suggested by practitioners in that medical specialty; Kübler-Ross stages of grief and Rodgers' empathy listening techniques were mentioned at length in training courses attended as part of fieldwork for this dissertation and at least one chaplain interviewed for this dissertation is a certified psychologist.

Table 7. Staff structure as of 2014, Hospital A

	Total	Regional total	Regional Hospital average	National Hospital Average
Physicians	1252	7690	303	281
Intern Physicians	n/a	3588	190	172
Nurses	1527	13992	400	404
Operational Assistants	1215	9503	351	346
Technical Assistants	582	5883	245	212

[19] Interview with chaplain, Hospital A University Hospital

Therapy/Diagnosis Assistants	407	3240	184	139
Other Skilled Staff	44	584	26	24
Other Non-Skilled Staff	n/a	1998	99	89

Sources: Staff report 2014 (ACSS), Annual Report 2014 CHLN, EPE

Table 8. Medical specialists in Hospital A as of 2014

	Total	Regional Total	Regional Hospital Average	National Hospital Average
Internal medicine	188	1202	80	57
General and family medicine	68	2564	27	47
Psychiatry	67	336	21	17

Source: SNS Staff report 2014 (ACSS)

Staff at Hospital A is structured around its position as a high-end backstop to other healthcare institutions. Because it is a reference hospital, it must lodge several medical specialties not available in hospitals. As mentioned before, this impacts religious assistance because it strains the positions of religion within hospitals. More specialized physicians tend to rely on technically complex treatment operations and tend to regards patients as illness carriers; this stands in sharp contrast to the position of religious assistance, which strives for a whole-person approach and, in effect, stakes its claim to legitimacy in modern hospitals by insisting that it humanizes hospitals through advocacy for whole-person approaches. This is the view of interviewees asked about operations at Hospital A, including the head chaplain of its SRAS. In the words of the Hindu representative, "that [Hospital A] is exactly why we need to have people with religious backgrounds in hospitals. Have you ever been there? All those corridors and wards filled with beds, it really is a demeaning experience". While organizational annual reports mention humanization efforts, there is no whole-hospital humanization policy or charter and unconfirmed reports of high burnout levels among staff members in Hospital A provide some context to the words of the head chaplain on the SRAS relationship to staff members: "Doctors do not come here often, but nurses do. Of course there are some who do not agree

with religion and think it should stay outside the hospital, but many come here and tell me about this or that patient who might need to talk to someone and be touched"[20].

6.2.1.2 Religious assistance services in Hospital A

In Hospital A, the Spiritual and Religious Assistance Service is located in the 4th floor of the main building. A sign indicates its whereabouts at the reception desk. Registration at the reception desk is mandatory in Portuguese public hospitals, unless users present accredited identification. Unknown persons are not allowed free entry and are forcibly removed from hospital wards if unable to show proper identification. Location seems to be important. As described by one interviewee, "In some hospitals, you need to go up and down stairs, up and down elevators, just to reach the chaplaincy… sometimes, the service is located so far into the building that it is almost impossible to reach it without asking around. The most glaring example of this is Hospital A. It is almost as if the hospital tries to hide the Service from plain sight"[21]. It shares a common area with a medical imaging department and an administrative section. The Service room is an average-sized and dimly lit chapel, fully decorated with Christian symbols, some overtly Roman Catholic. Outside, a number of leaflets and brochures advertise training opportunities. Virtually all of these are offered by some educational institutions outside the Hospital. There is also indication of mass service schedule and chaplains' contact information. Just before the chapel, a door to the left leads into a small office where chaplains work when inside the hospital. One participant mentioned how difficult it was to open the adjoining room, suggesting that hospital management had little interest in seeing it done.

The Service is led by one Roman Catholic chaplain and supported by two chaplains. The head chaplain is a Psychology graduate and has taught MA students in Ethics, Spirituality and Health at the Catholic University. He is currently the coordinator of a national Catholic chaplain network. The two remaining chaplains are not full-time: one is a deacon and the other is a recently-appointed member of the Dehonian congregation. Age structure is significant. The head chaplain is a middle-aged man, the deacon is entering a later life stage and the other chaplain is a young man, held in high esteem by one participant: "He is a bright young man, a dehonian… I think he will do just fine as a chaplain, he has human quality and social skills, knows how to act and could go far". The emphasis in this reference was not on the theological

[20] Interview, Hospital A head chaplain.
[21] Interview, Hindu representative

prowess or sacramental capacity of the young SRAS member; instead, human quality and social skills were mentioned as the most important features of a competent chaplain. Below, it is suggested that, while the Hospital A SRAS is the closest example of a traditional chaplaincy as regards the cases studied for this dissertation, interviews show that there is a willingness to pursue a strategy which could be proximate to that of Hospital C. During fieldwork, the actual physical space was scarcely used by identifiable staff or non-staff/patients. This holds little relevance as to the importance of the SRAS in the hospital itself: as mentioned before, the institution of chaplaincy in hospital does not operate within the constraints of physical space as its basic operational facility. As suggested by Wendy Cadge (2012), hospital chaplaincy is best understood, not as a physical instance, but as a set of practices, representations and social relations. These cross intra-organizational boundaries and boundaries between the organization itself and society. As suggested above, in the descriptive account of the Hospital A-specific religious assistance regime, boundary-crossing is one of the markers of cross-case specificity. In this SRAS, the hospital-society boundary is the most important marker. Intra-organizational boundaries at Hospital A are perceived by chaplains, both inside and outside the hospital, as either insurmountable or difficult to surpass. One participant asked me the following, as we discussed perceptions of SRAS general implantation in Portuguese hospitals: "Why do you think it is so difficult for the head chaplain of Hospital A SRAS to work within it?". When I asked this individual to develop the topic, he replied: "The problem is not just one of size; there are also other issues at work. Everyone knows that hospital administrations are chosen for their politics and their commitment to secularism… You know, most of them [hospital management personnel] are Freemasons"[22]. This suggests knowledge circulation among Catholic chaplains regarding the position of SRAS in large, secular hospitals. In any one of the three cases compared in this study, the quality of SRAS is never perceived as depending on the legal standing of religious and spiritual assistance or State-religion relations largely put. It is always an issue of interpersonal relations and the ability of actors to frame their actions and representations into demeanors that fit into the hospital. In Hospital A, the SRAS and its chaplains are largely unable to perform these framing operations because the symbolic opportunity structure never shifts towards openness or ambivalence towards spiritual and/or religious aspects of healthcare. The model at work is seen as strictly biomedical and, in some cases, it is seen as a negative development from the late 1970s. While this could be seen as pertaining to the religious assistance regime in Hospital A, it deeply impacts the service. The

[22] Interview, former Coordinator of Catholic Health Pastoral

Hospital A SRAS is comparatively more isolated within the hospital than other SRAS in very large hospitals. Paradoxically, one participant remarked that this is consequential in terms of inter-religious/ecumenical activity: "It is no coincidence that they, at Hospital A, are unable to perform religious service with other Christians, you see the difference between that and other big hospitals, just look at Hospital C or even Hospital B"[23]. These references were not primed into the interview, as I had not mentioned, at any stage, my comparative framework or my research into those cases. The comparison emerged throughout interviews. There is no indication that the Hospital A SRAS performs any distinctive interfaith/ecumenical activity. Furthermore, interviews conducted with Evangelical Alliance (congregational protestants and free churches) representatives indicate that, where barriers to access arise, these are often concentrated at Hospital A, and not specifically on hospital management stances. In Michael Lipsky's terms (2010), hospital street-level bureaucrats exert influence at the most basic organizational level. Reception desks at Hospital A either do not hold registries of certified representatives, which are to be kept by the SRAS head chaplain, or are seen as not paying them due attention; security personnel does not necessarily allow religious representatives to enter infirmaries or other wards after visiting hours and, since Catholic chaplains aren't always present in order to negotiate entrance with other street-level bureaucrats, may not be allowed access to patients. Representatives are also not issued ID cards, as happens at Hospital B.

Instead, the distinctive feature of this Service seems to be its relationship with volunteers. Although the Regulation on Spiritual and Religious Assistance allowed Services to organize volunteers, the Hospital A SRAS has pioneered a large-scale effort and preempted the legal bill. It sponsors a 250 volunteer-strong association which supports SRAS activities, namely those that are specifically linked to religious rituals. Importantly, the association is fully established within the Roman Catholic Church and abides by canonic law as well as civil law. This associative effort is looked upon with great interest by other chaplains and the model is expected, as of 2016, to be extended into other Dioceses. As discussed below, the outward strategic orientation of this religious assistance service has led its members to seek support outside the hospital. Its community orientation is a form of compensating for the lack of resources available within the hospital; the volunteering effort is a response to this. When the 2009 Bill entered into force, this was already defined as a priority to the Hospital A as a means of ensuring survival through disengagement from the hospital. By then, it was apparent to

[23] Interview, Hospital A SRAS head chaplain

members that action towards strengthening its ties to the existing Roman Catholic community was necessary in order to attain a minimal degree of legitimacy.

Chaplains are called and, to the extent that other social groups in the hospital allow it and their intra-organizational social capital permits, circulate in infirmaries and services in order to attend to what they perceive as patients' need for care. In this sense, Hospital A poses a double challenge.

First, it is no longer a self-sufficient facility. It is now part of a Hospital Center comprising two hospitals which, although close to each other, necessitate frequent displacement by any given chaplain. This SRAS must attend to two large-scale hospitals in the wake of changes in the hospital governance system. These changes strain chaplains' schedule while exerting pressure towards the removal of humanistic medicine. As stated by one interviewee: "Time is as much a resource as any technology. As doctors, we need to have time, to develop a relationship with patients"[24]. As a comparative problem, the question of strain in scheduling was raised in interviews, so as to determine how it impacted the Hospital C SRAS. However, one interviewee mentioned that "it is not really a problem. There is plenty of time to attend to the needs of our community. What is lacking is a proper relationship with hospital administration and most doctors working there". The same individual added that, regarding issues of comparability, "the real issue is that the city in which the hospital operates is too large and people do not trust one another in general. This is not really a problem of chaplains or lack of demand for religious assistance (…) but a problem of people not wanting to trust"[25] Chaplains mention the problem of time-straining in impersonal care institutions. Hospital A is the paramount example of output-oriented hospitals: physicians and nurses are resource-strained and pressed to conform to performance indicators. One chaplain mentions this while speaking about a young doctor who had committed suicide. Importantly, it closely channels the statements of another independently interviewed assistant at Hospital B SRAS: "I don't know how they [physicians and nurses] are supposed to work. When they go to college, it's like they have no lives, it's always about grades. Then they become interns and things worsen, they have little time for anything other than work for too long"[26]. Spiritual and religious assistance thrives on time, presence and support – indeed, the conversion of theological arguments into therapeutic guidelines seems to belie a framing strategy that underlines time and relationship development as pillars of care in a dehumanized setting. Hospital A allows for little headway into

[24] Interview, former Health Minister.
[25] Interview, former Coordinator of Catholic Health Pastoral.
[26] Interview, Hospital A SRAS Assistant

unrestrained relationship development. It is exemplary in its focus on outputs, given its position in the Portuguese hospital network. A functional argument would suggest that, given these constraints, a SRAS would seem useful to displace care concerns from nurses to chaplains. Instead, both nurses and chaplains are strained; while the former are seen as fully legitimate health professionals, the latter self-perceive as artificial plug-ins in the organization.

Second, Hospital A is perceived, as indicated in most interviews, as a large, impersonal and poorly organized institution. It is a dominant hospital where services are not necessarily close to each other according to functional need; further, as the city it is located in evolved towards a large metropolitan area and the hospital itself is an acute care, reference hospital, hospital management expanded its premises according to immediate need. These instances of organizational expansion have made physical circulation of human beings difficult in the eyes of one interviewee: "That is a very large hospital. It is too large, I think. I would say that, as opposed to other smaller hospitals, people never stop, never take the time to speak to patients or each other. You just need to stand outside wards and look at the sheer volume and speed of people going about. That constrains time and turns the hospital into a *corre-corre* [hurried] hospital"[27]. These remarks point to the connection between regime and service proposed in this study: in Hospital A, time as a subjective intuition and as a resource is scarce, and is thusly represented by chaplains. These individuals do not see their time as independent from physicians, nurses or other staff: as the organization responds to Hospital B-enforced goals on patient inflow/outflow in the context of scarce physical resources and diminishing conditions for cure and care, chaplains also perceive their presence and role to come under strain by results-oriented operations. The Regulation on Spiritual and Religious Assistance in Hospitals suggests a ratio of 1 spiritual assistant per 400 beds; this is perceived as scarce at the outset and untenable in practice.

Furthermore, evidence suggests that this particular SRAS is scarcely integrated in the hospital in other ways. As a teaching institution, Hospital A is seen as a beacon of technology-heavy medicine. While ethics, bioethics and humanistic medicine are nominally present in *curricula*, interviewees with backgrounds in ethics and chaplains suggest that these domains are afforded little footing in the education of physicians, in Hospital A more than other large-scale medical schools. This is an important issue to the Hospital A SRAS. Since, as opposed to the American model, there is no established Clinical Pastoral Education program, education is sought on a case-by-case basis by spiritual and religious assistants of any religious tradition. This provides,

[27] Interview, former Health Minister

in turn, further advantage to Catholic assistants, who benefit from Catholic-centered training at prestigious universities and the support of the Catholic Health Pastoral. However, this advantage belies the issue of incumbency and challenge. The Hospital A SRAS shows that organizational fields do not necessarily reproduce broader fields. Full-time chaplains in the service are informally allowed to circulate throughout the hospital, but access is not universal nor is it equitable among hospital wards. In SAF terms, Catholic chaplains are in constant flux between their position as incumbents, when the context is defined as interfaith or ecumenical, and challengers, when the context is defined as scientific or biomedical, as it often is in hospitals. This constant state of flux appears to be more evident in Hospital A, and may explain why this SRAS is more outward-focused but seems less interested in interfaith activity. For this social unit in particular, interfaith/ecumenical activity is not seen as strategically appropriate. The issue at stake is survival in a hostile organizational environment. As argued in the next section, this is due to the physical and social structure of the hospital, the legal framework surrounding the outer limits of social action motivated by religion in public institutions and contests over knowledge in organizations.

In the previous section, a broad picture emerges. The Hospital A SRAS faces a difficult situation in comparison with its Hospital B and Hospital C counterparts. It has partially engaged in an exit strategy: its staff focuses on training and organizing volunteers who engage in pastoral work as parish members. Voice is not an option in Hospital A. The organization is perceived as unwieldy. It is too large, too busy and too focused on technology-heavy cure. It is not an organization focused on care nor an organization invested in developing humanistic medicine. How individuals represent the hospital is as important as the actual attribute, because it presses individuals into certain discursive strategies. In other words, how the organization defines and constrains the role of religion exerts an impact on how chaplains and religious representatives deploy frames of reference when speaking about religion. This is one of the features of a religious assistance regime: it pertains to ideascapes and is a meaning-making construct. As argued before, religious assistance regimes are sets of formal procedures and organizational arrangements which position religious assistance in a given setting coupled with informal cognitive, representational and discursive schemes which structure how religious assistance is conceived by chaplains, religious representatives and hospital SRAS. In a meaningful sense, these regimes precede the service because they provide the backdrop against which services are provided and also a cognitive backdrop against which these services are interpreted by actors. When a hospital, such as Hospital A, presents technology-heavy medical

practice as the only meaningful content of medical practice, to the exclusion of other forms of knowledge (even medical science domains), it is significant because it pressures the religious assistance regime outward – to cross the organization-society boundary and survive as an interface –and, paradoxically, limits the extent to which chaplains and religious representatives define their roles via frames that bridge medical arguments and theological arguments. It would make sense to suggest that the opposite should happen: in an environment seen as hostile, actors would tend to become less contentious and engage in discursive strategies which should prevent any escalation resulting in loss of legitimacy. The conclusion would be the following: the religious assistance regime at Hospital A would emphasize religion as therapy and try to close the gap between non-empirical and empirical knowledge; it would underplay ritualized practice and hierarchy in favor of individualized meaning-making through references to spirituality – Catholic chaplains, for instance, would refer to patients' nondescript spirituality as a universal component of humanity, instead of referring to religious belonging or believing. Instead, the religious assistance regime sets the service into a pattern of outwardness and non-integration into hospital goals. While respected as such, full-time chaplains are not likely to be seen as health practitioners and, in interviews, are found to rarely see themselves as health practitioners. The SRAS is neither formally nor informally seen as part and parcel of the care or cure quadrants suggested by Mintzberg. Its staff's ability to traverse the quadrants is limited: transitioning from the cure quadrant to the care quadrant is seen as difficult because medical power is enhanced by the organizationally dominant paradigm. The command quadrant is seen as secularized and, by several interviewees, secularist. In other words, even though traversing quadrants towards the command quadrant is legally impossible, as public institutions are constitutionally forbidden from taking stands on confessional matters, individuals whose role definition is framed by non-empirical goals and belief systems – chaplains and religious representatives among them – are unable to influence organizational function. The only remaining quadrant is the initial one, that of community, and, as suggested, the Hospital A religious assistance regime is invested in strengthening its ties to externally-located community members, namely pastoral volunteers. This is why it has developed an extensive volunteer network that precedes the legal framework which establishes it as a fundamental component of religious assistance in hospitals. In Hospital A, if this were not a strategic priority, it is likely that the SRAS would be weakened to the extent of irrelevance. Reasons for this likelihood are provided in the next chapter, where a comparative analysis is performed.

Evidence-based medicine is clearly dominant in this hospital, and this may be observed both in the presence of specialist physicians, since the hospital is an acute care institution and the highest-level reference in many nationwide specialist networks (oncology, cardiology, etc.), and the comparative lack of importance of both internists (and internal medicine) and structures of humanization. One of the fundamental claims of this study is that religious assistance in hospitals – and likely in public institutions at large – is never disconnected from paradigm shifts, in this case from analytic anthropological paradigm to a holistic anthropological paradigm. These paradigm shifts do not occur in any linear fashion and paradigms may be concurrent in an institution. This is why technology-heavy specialties, such as radiology, may hold on to biomedical paradigms while humanistic-bent disciplines, such as psycho-oncology or internal medicine, are quickly transitioning into holistic perceptions of the human being, thus bridging a gap with the SRAS. Humanization is the concrete implementation of these shifts. And it is important to note that religious assistance is often seen as integral to humanization, not only by religious representatives and chaplains but also medical personnel in charge of humanization. Among the three cases presented in this study, Hospital A is the organization least concerned with humanization procedures. While humanization has been recognized, to variable extents, at Hospital B and Hospital C, it is held as secondary in Hospital A. The religious assistance regime is thus built in opposition to the organizational environment. The head chaplain holds a seat at the ethics committee, but there is scant evidence of any influence exerted towards humanization. This occurs in clear contrast with the Hospital B and Hospital A cases, where chaplains see themselves, and frequently seen as such by their peers, as full members of hospital staff. Fieldwork at each hospital shows this: interviews with both the Hospital B and Hospital C SRAS staff were constantly interrupted by requests from volunteers, patients or persons using chapel facilities. Interviews at Hospital A went on uninterrupted and chapel facilities were mostly empty. Whereas in Hospital C the SRAS was part and parcel of the most advanced humanization initiative in Portuguese hospitals, the Hospital A SRAS is unable to advance the discussion into more concrete territory. Humanization initiatives are formulated in terms of improving service quality. The basic task of finding out who headed the humanization committee at Hospital A, for the purpose of requesting an interview, failed. No individual spoken to had any knowledge of who was a member of the humanization committee or what it did – in telephone calls, I was frequently referred to the Ethics committee. The physician we were referred to presented himself as head of the Logistics department and seemed puzzled by a request for an interview on humanization procedures. This anecdotal event is best understood as a micro-component of an organizational

tendency towards devaluation of humanistic medicine, which, as suggested throughout this study, is tantamount to the closure of organizational support or a base level of acquiescence towards religious assistance. None of these exist in Hospital A, which provides two basic insights into the prevailing religious assistance regime in the organization.

First, the higher-level religious assistance regime as provided by law has not had a measurable level of impact in this hospital. The double dominance of technology-heavy medicine and traditional medical power, on the hospital's cure quadrant, is linked to institutional dysfunction as regards the command quadrant: management boards are not perceived to function properly by chaplains, both in and outside the hospital. These features exist in a context where humanization is not seen as a priority. Hospital A is a very large, cure-focused institution with clear biomedical objectives: it is focused on increasing the ratio of outgoing patients at the lowest possible cost. Care-focused services, such as the SRAS, are seen as non-essential. Furthermore, Hospital A SRAS exists in a vacuum that does not exist in Hospital B and Hospital C. In these instances, there is an understanding, albeit not translated into actually existing organizational features, of humanization as an important component of hospital life, as in Hospital B, or humanization has emerged as an institutional priority to the extent of being seen as a distinctive feature, as in Hospital C. As part of the research process, I sought to contact the physician in charge of the humanization committee at Hospital A. The call-center staff had no knowledge of such a committee. After some time spent on the phone, I had spoken to three different departments, none of which had any knowledge of a working humanization committee. I was provided with the contact of a physician whom I was told, was the head of the humanization committee. After contacting the physician, I was told he was the head of the Logistics and Stock department and that, while his cooperation was not in question, any research on religious assistance in hospitals would likely not be interested in logistics and stocks. This anecdotal event led us to look for evidence of the Hospital A humanization committee having met at all in the nine years since it was established. No evidence was found. In interviews, Hospital A was referred to as a difficult environment where humanization was not a priority. The religious assistance regime is not underpinned by the issue of humanization: chaplains and other religious representatives were unable to build bridges across organizational boundaries because, no matter how skillful they were, organizational discourse, practice and structure did not allow for the issue of humanization, and the role of SRAS in its buildup, to become relevant. In this sense, the religious assistance regime at Hospital A is service-disabling: it pushes the SRAS to disengage from organizational life and excludes the SRAS

from organizational life. This double dynamic is likely the most important reason for the outward, community focus of the Hospital A SRAS. Furthermore, Hospital A is a vertical organization with low boundary crossing. In organizations with strict and static power structures, crossing boundaries entails high risks and potential costs to actors. This is also an important conjecture regarding the Hospital A SRAS: it does not engage in multi-faith or ecumenical relationship building, as is the case in Hospital B and, to a lesser extent, Hospital C. Instead, it focuses heavily on community-building within the Roman Catholic Church and specifically with parish members who might be able to perform volunteer pastoral duties. This is due to a restrictive organizational environment and a focus on survival.

6.2.1.3 Conclusion

Hospital A lies at one end of a continuum which is detailed in the following chapter. It is a highly restrictive organizational environment where the cure quadrant and a focus on patient outflow are supported by a vertical power structure. Religious assistance, according to SRAS members, is not seen as legitimate and does not have enough status or reputation to hedge the costs of traversing internal boundaries. These constraints are illustrated by a lack of humanization policy initiatives. Although its head chaplain is highly regarded by other chaplains and religious representatives, there is evidence that there is a lack of skills and resources in order to counteract organizational resistance to religious assistance. The SRAS has thus focused on traversing external boundaries and seeks to mobilize community resources in order to secure survival. This restricts efforts towards multi-faith engagement, even though religious demographics suggest that demand for multi-faith religious assistance should be comparatively higher than in most other Portuguese hospitals.

6.2.2 Hospital B

Hospital B is a very large-scale hospital even in the context of Portuguese high-end public hospitals. It is highly ranked on several specialties, it is branded first and foremost as a university hospital. As a modern facility, its emergence dates back to the first half of the 20th Century. In the second half of the century, it became specific in the incipient Portuguese hospital system as a School Hospital and afforded specific regulations given its triple role as a hospital, a research facility and an education institution.

As the University attracts a highly diverse community, including students, staff and the wider supporting economy, Hospital B seems to have driven the process of organizational innovation

regarding spiritual care in hospitals; Catholic chaplains are committed (and have been supported in doing so) to include non-Catholic Christian spiritual assistants, from nearby communities – namely from newer evangelical churches emerging from the Brazilian community – into the chaplaincy roster. The religious and spiritual care service merits its own space and started functioning before 2009. Management is highly professionalized. Opinions on relations between chaplains and administration are divided. The head chaplain as mentioned above, remains unconvinced by hospital administration teams but states that the incumbent team until 2009 was more cooperative than the current (as of 2015) one. One of his assistants sees relations as cooperative: "I never had any issue in contacts with the administration (…), they recognize the work we do and its worthiness"[28]. The full-time staff includes a head chaplain and two assistants. The Hospital B SRAS has implemented an innovation in SRAS management: a multi-faith roster of community-appointed representatives with fully scheduled responsibilities. It is printed and updated each week so as to reflect availability and roster appointees may be on call for emergency situations. Perceptions of other chaplaincy services on Hospital B chaplaincy are very favorable and held as exemplary, as stated by the chaplain of Hospital C: "the service at Hospital B is more advanced in terms of multifaith dialogue than anywhere else in Portugal"[29]. The Coordinator of the Roman Catholic Health Pastoral replied to queries into the status of Hospital B SRAS in the wider context of religious assistance in Portugal as follows: "That is exactly what I want to talk about when I think about modern-day chaplaincy. We live in modern times and there is no point in trying to be ignorant of how Portugal has changed (…) we are still Catholic, we are still mostly Catholic, but we need to recognize that people from other religions are entitled to their own support"[30]. Its activities as a University Hospital are deeply embedded into its organizational functioning, as many foreign students are also hospital users and a number of communities living within urban limits are also users. However, the College of Medicine lacks any research center or graduate work on bioethics. Hospital B holds an Ethics committee, where the head of the chaplaincy serves as a board member, but lacks a Humanization committee, suggesting a less linear relationship between these institutional features and patterns of spiritual and religious care.

[28] Interview, Hospital B SRAS assistant
[29] Interview, Hospital C SRAS head chaplain
[30] Interview, Coordinator of Catholic Health Pastoral

6.2.2.1 Staff structure and relations with religious assistance

Table 1 shows Hospital B staff structure as of 2014. It reports a wide gap between the hospital and its regional counterparts. It exerts more influence at a regional level than either Hospital A or C and is more human resource-heavy than other high-end hospitals. This is due to the comparative lower density of healthcare facilities in its target region: instead of serving as a hub hospital, it is both dominant and comprehensive; recent reforms have enhanced its regional and national position as the only reference center for heart-related surgery. Its size, while not as commanding as that of Hospital A, is unusual in terms of its urban placement. Its staff size largely surpasses either Hospital A or C, particularly as regards nursing staff. This is indicative of the role of care: there is an imbalance between nursing staff and specialist physicians which is further reinforced by the large number of psychiatrists and general/family medical practitioners employed in its ranks. It is indicative of a supportive environment for religious assistance. The strategic outlook of the Hospital A SRAS is a reaction to these conditions: the costs of operating across internal boundaries are significantly lower than in Hospital A, where opportunities for allegiance between SRAS members and more open staff members are lower, but significantly higher than in Hospital C, where SRAS members have initiated a transition from traditional chaplaincy to a fully accredited hospital service in charge of managing the spiritual needs of patients.

Table 9. Staff structure as of 2014, Hospital B

	Total	Regional total	Regional Hospital average	National Hospital Average
Physicians	970	3639	209	281
Intern Physicians	747	1758	168	172
Nurses	2611	7924	282	404
Operational Assistants	1578	4986	202	346
Technical Assistants	708	3023	150	212
Therapy/Diagnosis Assistants	467	1450	102	139
Other Skilled Staff	118	344	25	24
Other Non-Skilled Staff	212	1248	63	89

Sources: Staff report 2014 (ACSS)

Table 10. Medical specialists in Hospital B as of 2014

	Total	Regional Total	Regional Hospital Average	National Hospital Average
Internal medicine	114	453		57
General and family medicine	68	1515	39	47
Psychiatry	79	154	14	17

Source: SNS Staff report 2014 (ACSS)

6.2.2.2 Religious assistance services in Hospital B

The Hospital B SRAS operates from a ground-floor chapel in the main hospital building. It is a quaint, dimly lit room where Catholic symbols are smaller, in comparison with hospital A, and could be easily displaced, being both small and light (a cross and some paraphernalia) in contrast with Hospital A, where Catholic symbols are firmly stuck to walls. . Catholic mass is held every day at 17h15m; special service is held on Sundays and Catholic holidays. A nearby room serves as an office where SRAS members talk to patients and medical staff.

In this SRAS, staff structure is comparatively complex. Membership is regarded as full when individuals are part of a mechanism which institutes a time schedule. In this sense, full membership is assigned to all religious representatives; partial membership does not exist as such. This is the perceived state of play in Hospital B SRAS. One interviewee stated that "this was the first… and I think only… idea, initiative leading to an interfaith spiritual assistance service"[31]. Upon closer inspection, Hospital B SRAS is neither interfaith nor fully horizontal – there is a strict hierarchy based on the role of the head chaplain within the institution and the leading role played by Catholic representatives in the service. It is also not interfaith. It is ecumenical, although, as of late 2014, talks of a Muslim representative entering the assistants' roster are in an advanced stage. In this service, members of several Christian traditions are partial SRAS members. These include Methodists, Mormons, 7th Day Adventists and two Congregationalist traditions, a Baptist Church and a Christian Life Church. During fieldwork, it became clear that 7th Day Adventist and Assembly of God pastors are the most active and vocal in this organizational experience; however, these traditions are almost entirely focused

[31] Interview, 7th Day Adventist representative

on community development outside hospital boundaries. In this sense, Hospital B SRAS is structured around the second axis mentioned previously, that of full/partial membership, as much as around the first, that of employment status. Informal discussions with members show that two cleavages may be identified when one discusses the issue of membership. If one discusses intra-service dynamics, concerns over representativeness and horizontal relationships emerge: 7th Day Adventists are keen to uphold their representations of assistance in collective discussions. However, as one reframes the debate into the larger universe of Portuguese public hospitals, the status of Hospital B SRAS is recognized as unique. Furthermore, opening up the service is perceived as an evolutionary step. In informal conversation with SRAS members, I was told about the reaction of physicians to this enlargement: "Once I sent the new schedule through the hospital email system, I was told that physicians reacted in disbelief, saying things like "How can these people get together and do something like this if we [clinical directors] can't get along?". As reported by the interviewee, physicians in this hospital, particularly those in decision-making positions, do not have very smooth working relationships. This was told to me in rather colorful language; it is indicative of two SRAS features which seem unique to Hospital B. First, this service holds coalition-building to be the core of its survival strategy. While the regulatory bill which enforced transition from chaplaincy to SRAS entered into force in late 2009, chaplains engaged in talks towards the establishment of ecumenical service schedule in mid-2008, just as the protracted and difficult policy process described above was about to come to an end. At Hospital B, chaplains were sensitive to the policy problem and adequately familiar with the process, in sharp contrast with the other religious representatives, who have no significant knowledge of preceding conditions or the complications of policy, where the Catholic Church had to employ its influence to an important extent. There is a clear connection between the formation of an ecumenical service and the policy measure discussed before, but the resources needed to establish a legitimate ecumenical SRAS had to be in place. The organizational opportunity structure become open, but chaplains and religious representatives held the resources (influence and legitimacy) required by the critical juncture to establish the new structure. This is discussed in more detail below, as the religious assistance regime effectively shifted into a set of unique structural conditions and performative possibilities. Second, the surprise conveyed by physicians, at least as represented by chaplains, is a manifestation of the increasing contestedness of both organizational boundaries, since non-Catholic representatives are not funded by the State and are not necessarily representatives of demographically relevant hospital constituencies, and medical power, which is traditionally asserted through high levels of professional corporatism and low levels of dissent. Later, I was

told by three chaplains working outside the three cases analyzed in this study, that hospital chaplains were about to become the first quasi-professional association in the Portuguese Catholic Church. In their words, "not even the Catholic Moral and Religious education teachers [working in public or private schools] have been able to convince the Bishops".

Hospital B is the largest hospital in a region where religious belief and belonging is very high by European standards; it is comparatively disproportionate in size when compared to Hospital A, for example. In this sense, it is not a dominant but a hub hospital, highly connected to the national hospital network and the circulation of information across institutions and among staff members. The connectedness of Hospital B contrasts heavily with the isolated character of Hospital A. Hospital B SRAS members are well informed about other hospitals in the region and most religious representatives know each other on the basis of their connection to Hospital B. Upon observing relationship patterns in collective discussion among representatives in the region, it became clear that the full Hospital B SRAS members function as hubs in the regional network; the head chaplain functions as an informational gatekeeper because of his location at Hospital B and because of his SRAS' pioneer work in shifting the pre-2009 paradigm into one adapted to current legislation. It is important to note that this transition began before 2009 and the externally-enforced paradigm shift it entailed; transition into an ecumenical service, which is seen as a stepping-stone towards full interfaith service provision, began in early 2008. This transition is seen as important to members of Hospital B SRAS; it is seen as pioneering and exceptional. Further, it is the single service where two women are members: in addition to the Catholic nun mentioned above, a Methodist pastor also remains a member, even after having moved out of the urban area. In fieldwork outside the hospital setting, the gender structure of chaplaincy becomes clearer: in discussions during a meeting at a Catholic facility, it is clear that, in this particular service, the weight of institutional entrepreneurship is felt by all participants, as the guidance of the head chaplain is clear at all stages, as this individual leads the service, coordinates the network of chaplains in the region and strives to keep debates in check. Interestingly, fieldwork outside the hospital shows that this service holds a unique attribute: it fosters its relationship with psychiatrists and its head chaplain seeks to deploy skills gleaned from self-teaching in psychiatry. Informally, the work of Carl Rogers and Elizabeth Kübler-Ross are discussed, not as interesting, but actually operative: all participants in this study affiliated with Hospital B SRAS show at least some familiarity with the concepts of Rogers and Kübler-Ross and support this impression with empirical examples taken from their work as religious assistants. In two separate occasions, psychiatrists from Hospital B were invited by the SRAS to speak at training events. The discursive congruence of Hospital B

SRAS members and the two psychiatrists – both specialists in the field of psycho-oncology – is one of the most interesting aspects of this relationship; allusions by the two physicians to the work of Hospital B SRAS suggests high levels of legitimacy within specific sectors in the medical field of Hospital B. It is more interesting to this study, however, to note that choosing psychiatry, while a seemingly trivial option, since religious care might be conceived as psychosocial support with spiritual undertones, is more likely to manifest a strategic choice by Hospital B SRAS. As a service, its levels of legitimacy stand to benefit from these decisions.

Furthermore, Hospital B SRAS supports a number of services in the wider hospital. Its head chaplain, as mentioned above, is a full member of the hospital ethics committee and coordinates volunteer efforts. In informal conversations, this individual mentions an important distinction in volunteer work. On the one hand, social volunteering is a non-specialist venture; he provides anecdotes which illustrate hospital life and the complex interaction of two hospital quadrants: community and care. Social volunteering is institutionalized into non-profit associations which are commonly named "Liga de Amigos do Hospital", translated as "The League of Friends of the Hospital". The significance of these naming conventions is not a minor detail. These institutionalized volunteer efforts offer minor training opportunities to hospital volunteers. These are individuals who commit time to the care quadrant of the hospital, namely in the provision of meals to patients or in providing company to patients without identifiable family members these volunteers are known to suffer from burnout at very early stages in their commitments and are thus trained in self-protection. The Hospital B SRAS head chaplain does not speak derisively of these volunteers, but it is clear that the SRAS is a separate venture. In this context, the chaplain discusses differences between social and pastoral volunteering, using the example of Hospital A SRAS community efforts. Pastoral volunteers must be able to engage in the ministry of presence. This is a common requirement of chaplains and accredited religious assistants, and so the pastoral volunteers must also be able to provide the ideological apparatus that legitimizes the SRAS. In other words, pastoral volunteers are not "simply" hospital volunteers as stereotypically expected: they are not food-handlers or talking heads. Instead, pastoral volunteers are mission-based; the Hospital B SRAS head chaplain speaks highly of this idealized character. So far, the service has been unable to provide training on a mass scale. However, it is perceived as a major step forward and, at two training events attended during fieldwork, the Hospital A pastoral volunteering effort was suggested as a best practice benchmark.

In contrast to Hospital A and Hospital C, the Hospital B SRAS regime is neither driven by legitimacy nor integration. Its institutionalization is not complete; the SRAS regime holds at a level which mediates between Hospital A, which is at best coercively institutionalized, and Hospital C, which has stepped beyond coercive institutionalization and is now in the process of becoming normatively and cognitively institutionalized. The Hospital B SRAS holds a unique position in this comparison. Since Hospital B is the largest hospital in the region and is not the object of strong competition, it is best characterized as a comprehensive hospital. Comprehensive hospitals show specific institutional features: they are more insulated from the organizational field than dominant or hub hospitals, which need to interact with other hospitals in close physical proximity, and thus are less pressured to comply with normative and coercive standards. This opens the organizational opportunity structure for Hospital B SRAS members. The question is whether these individuals hold the resources necessary to frame their work and strive towards gains in legitimacy, status and reputation. The problem space for this service is that of legitimacy, not of status or reputation. Regarding status, it is clear, at the level of the organization as well as at field level, that the head chaplain is able to muster resources; otherwise, the introduction of organizational innovation towards an ecumenical service would likely have been more difficult than it has been.

Reputation-wise, the service is held to be an important example in the wider organizational field. According to a policy official, the head chaplain at this hospital is "the best example of what a chaplain should be in a modern hospital. He is neither beholden to the Church nor does he try to represent himself as some sort of witch doctor. He is a priest, first and foremost, but he finds his priesthood in listening to people in need"[32]. The 7th Day Adventist representative also speaks highly of the chaplain and his assistants: "I know a lot of priests who are not open to welcoming other communities. For him [the Hospital B SRAS head chaplain], that has never been the case. When he recognizes a patient from my community, he calls me. He tries to welcome everyone"[33]. Chaplains and religious representatives speak highly of the Hospital B SRAS and the head chaplain is recognized as an important voice in what is seen as the professional group of healthcare chaplains. However, the SRAS relationship with management is sometimes frayed. The head chaplain speaks of this relationship in strong terms: "Sometimes it works, sometimes it doesn't. It all depends on who is heading hospital administration.

[32] Interview, former Health Minister.
[33] Interview, 7th Day Adventist representative.

Currently, I don't care for them. But my work doesn't really depend on them. It depends on people continuing to need a supporting presence". This individual formulates his work in terms which are proximate to those stated by Sullivan – religious assistance is first and foremost a ministry of presence.

It is also important to note that chaplains and religious representatives connected to Hospital B, because of regional proximity or personal ties, are the most vocal in criticizing management. They compare former management teams, especially the team which oversaw the 2008-2009 transition into relational-ecumenical care, favorably to the current team. However, it is clear, from interviews, that access to management is not laden with conflict or indifference, as suggested by Hospital A SRAS members. Instead, Hospital B SRAS shows a high level of embeddedness into the organization: its members are highly articulate in speaking about Hospital B's mission, needs and goals; they report no difficulty in traversing organizational quadrants, accessing medical staff or getting their voices heard. Hospital A SRAS chooses exit by deploying resources into community building, while Hospital B SRAS chooses voice by working with existing hospital committees. Individuals who choose voice do so because they expect to be heard and eventually steer the organization into their preferred direction (Brunsson 1989; Hirschman 1970). This fits into Hospital B SRAS members' organizational behavior. The religious assistance regime of Hospital B SRAS service does not face the problem of establishing legitimacy. The SRAS at Hospital B acts upon institutional exigencies in order to reframe and restructure the regime according to what it perceives to be the best configuration of religious assistance. There is minimal evidence of a sacramental model of religious care; instead, this service is engaged in multiple relational networks within and outside organizational boundaries. Two types of relationship show as much: how this SRAS relates to the psychiatry service and how this SRAS engages in inclusion of other Christian traditions and, more recently, with world religion traditions. The former is an illustration of quadrant fluidity: the service is able to traverse hospitals quadrants without incurring in costs that Hospital A SRAS members are familiar with. But traversing these intra-organizational boundaries is not so easy as to allow the service to disengage from community building. The latter relationship is thus relevant: while speaking of pastoral volunteering with a measure of urgency, Hospital B SRAS invests more resources and social skill into developing relationship with non-Catholic representatives than with nearby parish members. A trivial explanation would be that these communities are there by default: they need not be built or developed. But

the example of Hospital A shows otherwise, and the inward strategy of Hospital C reinforces this notion.

One of the defining features of this SRAS is its rigid representation of organizational boundaries. More so than in the two other services, Hospital B SRAS operates in a local order defined by the juxtaposition of sacred and public. As mentioned above, one of the more interesting problem spaces in researching religion within public institutions is the negotiated character of publicness and sacredness. In Hospital B, these notions are negotiated by juxtaposition: the hospital is sacred not *despite* its public character but *because* of it. The head chaplain mentions this explicitly: "I am working in a public hospital and I have a sense of duty… I see my hospital as sacred and it is in my interest to keep it clean from people who come here and try to talk to patients about faith healing and other such drivel. This is my duty (…) it's also in my interest because I do not want to have religion seen in this hospital as including such people, who can't respect the needs of people in suffering".[34]

An interesting proposition, which could be investigated through comparison between private and public hospitals, is that medicalization in public hospitals does not result in commodified medical bodies. In public hospitals, the medical body might precede the holy body, in Norwood's (2006) terms, but the holy body in Hospital B never ceases to be so within a public space. Hospital B SRAS members have an acute perception of boundaries because they perceive them to be porous and fragile. When these individuals speak of their duty as gatekeepers, they are speaking of the needs of the institutionalized religious field and their internalization of claims to legitimacy at a broader scale. But they are also framing hospitals as spaces of sacredness insofar as they register the inherent fragility of patients and seek to protect them from harm, regardless of whether it arises from excessive medicalization or from proselytism enacted by some religious organizations.

As it deploys resources into coalition building with other religious traditions to a larger extent than the two other cases studied here, the religious assistance regime is defined by ambivalence. The Hospital B SRAS is not as driven to parish-centered community building strategies as its Hospital A counterpart because its survival is never at stake. In effect, evidence that its move towards a multi-faith roster preceded the 2009 Regulation is sufficiently strong to suggest that, as a consequence of SRAS members being more knowledgeable than most on the specifics of

[34] Interview, Hospital B SRAS head chaplain

the legal bill, they were able to preempt most of its consequences without being forced to adapt extensively. These preemptive measures had important consequences: this is the only SRAS where members are fully registered and able to enter hospital premises without being, at least on occasion, forced to rely on the willingness of employed SRAS staff to engage with reception and security staff in order to secure entrance. It is also the only SRAS whose head chaplain speaks of a "duty of safekeeping" and the maintenance of sacredness by withholding access into premises by those religious traditions which are not recognized as such by legitimate actors in the religious field.

The religious assistance regime at Hospital B exemplifies transition. It is no longer a traditional chaplaincy where single faith sacraments are offered to patients. Its focus no longer lies in end-of-life wards, where chaplains would be traditionally secured freedom of movement. Instead, it frames itself as a community center geared towards support for persons in need, namely those hospital patients which are known to have requested – either formally or informally – spiritual care; the head chaplain speaks of sacramental duties as necessary but insufficient: "of course we are here to provide sacramental care (…), my duty here is first and foremost as a priest. But I am fundamentally someone who listens, who provides an attentive hear and compassion in times when hospitals are more interested in getting people out than treating them as human"[35]. Traditional chaplaincies in Portugal do not regard multi-faith rosters as fundamental components of religious assistance. In the case of Hospital B, that is an important mission component.

6.2.2.3 Conclusion

Hospital B is a mixed case. It is a somewhat restrictive organizational environment where the care quadrant is afforded some legitimacy. Religious assistance, according to SRAS members, is seen as somewhat legitimate. The costs of boundary traversal within the hospital are bearable, as there is evidence that SRAS members do not engage in external boundary traversal to a large extent, but engagement in coalition building with other religious traditions, with associated institutional adaptations, shows some outward strategic focus, as does a focus on differentiated community development through the organization of pastoral volunteering as competition to traditional volunteering within the hospital. Constraints are significant, but

[35] Interview, Hospital B SRAS head chaplain.

legitimacy, status and reputation are not at stake. Instead, SRAS members focus on humanization efforts.

6.2.3 Hospital C

Hospital C is a large hospital in one of the largest cities in Portugal. It ranks highest in medical performance on many specialties and its size/staff ratio is the largest, as it employs more nurses and physicians than Hospital A or Hospital B. As in these cases, it is located in a comparatively diverse human setting and its management is highly professionalized.

The history of Hospital C dates back to the 1930s, as the building project was approved, part of a policy built towards the extension of healthcare and medical education. It started operating in the late 1950s and was afforded exceptional status as one of the few high-end healthcare facilities in Portugal. As the previous cases, all medical specialties are offered in its premises.

There is no non-Catholic member of the chaplaincy roster, but there are plans for a multi-faith prayer hall extending beyond the hospital chapel. The incumbent chaplain is a member of the European Chaplaincy Network, the national coordinator of Hospital Chaplains and a vocal supporter in Portuguese society of the role of religion in humanizing hospital settings and medical care. As an early adopter of what may be labeled as a post-modern perspective on the role of religion in healthcare and hospitals, this individual has been especially important in establishing legitimacy for religious practice within medical settings and has played an important role in policy-making; the hospital administration has been comparatively open to the active integration of spiritual assistance into organizational care, especially in comparison with Hospital A. Hospital C has been commonly brought up in interviews with representatives from religious traditions as exemplary in how, as an organization, it has negotiated the role of religion within premises and regarding chaplaincy services as part and parcel of integrated care. A Hindu representative stated that "services here [Hospital A] have much to learn from Hospital C"[36], while the Buddhist representative added that "all of this [the joint work of religious traditions] is due to the work of the chaplain from Hospital C (…), without him and the Catholics we wouldn't be able to have a voice over how things are done"[37]. Hospital C is also specific in this case selection and unique in the universe of Portuguese hospitals because it puts special emphasis on the humanization of care. It recognized the need for a Humanization department and a Humanization Charter. The head chaplain is a member of the first and was

[36] Interview, Hindu community representative for health.
[37] Interview,Buddhist community representative for health.

instrumental in the writing of the latter. Interestingly, the hospital Ethics Committee does not include chaplains as members.

6.2.3.1 Staff structure and relations with religious assistance

The staff structure of Hospital C strikes a balance between the physician-heavy structure of Hospital A and the nursing staff-heavy structure of Hospital B. It is not as relevant, from a regional standpoint, as Hospital B but it clearly surpasses regional and national averages in terms of staff significance. In this sense, both Hospital B and C are more biased towards the care quadrant – and thus less cure-focused – than Hospital A. In the case of Hospital C, this is further confirmed by the implementation of care-focused policies and services, namely its Humanization Charter and Humanization Service. The former is recognized as a whole-organization priority and the hospital has implemented several cutting-edge initiatives towards patient-centered care. The latter is the foremost service of its sort in the Portuguese hospital network. It is recognized by practitioners as a leading institution in humanization and the operationalization of humanistic principles in medical practice. In an interview with a member of the National Council for Ethics in Life Sciences, the Humanization Service was extolled as "probably the most important thing going on in terms of applied bioethics in Portugal… the director of the service is an extraordinary individual and you can sense that the hospital is different from others where people are not treated as human beings"[38]

Hospital C employs a very high number of non-physician, non-nursing staff members. This is related to the overall strategy of Hospital B towards quality assurance and humanization.

Table 11. Staff structure as of 2014, Hospital C

	Total	Regional total	Regional Hospital average	National Hospital Average
Physicians	843	7137	335	281
Intern Physicians	714	3732	190	172
Nurses	2010	13627	488	404
Operational Assistants	1091	8601	407	346
Technical Assistants	394	5435	212	212
Therapy/Diagnosis Assistants	334	2216	127	139

[38] Interview, National Council for Ethics in Life Sciences representative.

Other Skilled Staff	247	531	24	24
Other Non-Skilled Staff	n/a	1996	93	89

Sources: Staff report 2014 (ACSS), Annual Report 2014 CHSJ, EPE

Table 12. Medical specialists in Hospital C as of 2014

	Total	Regional Total	Regional Hospital Average	National Hospital Average
Internal medicine	188	1202	80	57
General and family medicine	72	3187	67	47
Psychiatry	67	336	21	17

Source: SNS Staff report 2014 (ACSS)

6.2.3.2 Religious assistance services in Hospital C

The Hospital C chapel stands at the top floor of the main hospital building. It is a modern, well-lit space with 240 seats. Its motives are Catholic, but its decoration is sparse: the altar space takes up most of front section and seats are sided by large aisles. Its spacious disposition presents a striking contrast to Hospital A and Hospital B. Access is also easier than in the other hospitals: an elevator takes one directly to the top floor where the chapel is located. The head chaplain explains that location is not coincidental nor does it occupy an otherwise-vacant site in the hospital. In his words, "chapels should be located at a dignified location, so they must be as close to Heaven as possible; this is why our chapel is here, at the uppermost floor, to be closer to God and to serve as a reminder that religion is important in this space". This interesting quote points us to an important feature of Hospital C SRAS: it is not hidden in plain sight, as Hospital A, nor is it located in an ambivalent place, as in Hospital B. In maintaining this, the head chaplain is signaling the enhanced position, legitimacy and, arguably, status and reputation of the SRAS within the hospital. Its location at the top floor also serves a strategic purpose: the chapel is as close to other main building wards as possible. Since chaplains do not face the same restrictions as in Hospital A and are allowed to circulate freely throughout wards, this is presented by the SRAS team as a sensible compromise. Further, it is said that, as the hospital started operating, the need for a large, spacious chapel was immediately recognized and advanced by the founding physician, who is quoted as saying that "my hospital will not

hold a chapel that looks like a small store, as they have it in Hospital A". The socio-symbolic structure of Hospital C is also relevant to the policy process of religious assistance: three decision-makers mention, in interviews, the example of Hospital C as both unique and peculiar in the Portuguese hospital context. One of the top officials states, in trying to illustrate how important a balance between constitutional aconfessionality and the need to accommodate institutionalized practices and traditions is, that "it would be ridiculous to ordain the immediate removal of all religious symbols from, say, Hospital C, even if their presence is illegal under the Constitution, don't you think? I could not do that and more importantly I would not do that, because nobody wants to engage the Church in such a hostile way, we need to be conscious of their [Church] history and social significance"[39]. Another decision-maker mentions that "Hospital C has a much more relaxed attitude towards religion, just look at the head chaplain there, the status he has, the reputation, he's able to circulate in the hospital and nobody would think of telling him that he is not allowed to go here or there"[40]. The SRAS at Hospital C enjoys better access and conditions, and this is recognized internally and externally. In effect, this service is mentioned many times in interviews with individuals acquainted with religious assistance in Portuguese hospitals. It is the flagship service to Catholic chaplains, non-Catholic religious representatives and decision-makers. Even if, as regards religious diversity, it has not advanced to the same extent as Hospital B, there is an important connection between the institutional role of chaplains in this hospital and the head chaplain's policy entrepreneurship. Only the Hospital C head chaplain is known on a personal basis by some decision-makers; all individuals interviewed know the Hospital C head chaplain. As argued in this section, social skill and institutional entrepreneurship explain much of what is observed as regards Hospital C SRAS.

The Hospital C SRAS employs one full-time chaplain and two part-time chaplains. The full-time chaplain has worked in the hospital for over 15 years. A highly educated and articulate individual, it is apparent at the outset that much of what Hospital C SRAS is able to do and represent derives from his institutional entrepreneurship. The 2009 Bill on Spiritual and Religious Assistance in Hospitals is, by all interviewees' admission, as much a product of State-religion relations as it is a product of his effort; the political turmoil that followed the 2007 controversy had as much to do with internal conflict within the Ministry of Health as with

[39] Interview, former Health Minister
[40] Interview, former Health State Secretary

this chaplain's media salience. His presence enables Hospital C SRAS to remain committed to the organization without losing salience as regards other SRAS: his name is spoken of frequently in interviews with religious representatives and he is the only chaplain to engage in extensive European networking; furthermore, transnational networking is seen as an important factor in enhancing legitimacy across the religious assistance community. In 2013, he was awarded a PhD in Bioethics; his published work is one of the most important academic reflections on death and dying in hospitals. In conversation, he speaks of what drove him to write: a subjective lack of humanity in the hospital, which he perceives to affect both staff and patients. This is paramount to Hospital C SRAS: much more than in Hospital A or Hospital B, the focus here is on humanization and a more analytic approach to religious assistance. The Hospital C SRAS is also engaged in deeper coalition-building efforts than the other services: it is seen as a full member of support staff units and the head chaplain is a member of the Ethics Committee and the Humanization Service. As shown above, humanization services are lacking in both Hospital A or Hospital B; its emergence and institutionalization as a service instead of a unit or committee is said to have been the result of coalition-building by the SRAS and a number of pediatricians: "The [humanization] service director is probably the most important piece of the puzzle, but none of it would have come it existence without the support of a strong management board and the chaplaincy"[41], suggests one policy-maker. This opinion is shared by several actors who are at least partially familiar with the process of institutionalization of the humanization service. Upon analysis, it becomes clear that humanization, in the context of Hospital C's organizational performance, seeks to translate a number of bioethical concerns into operational practice. It is also clear that many of these concerns are shared and channeled by religious assistance providers: the Hospital C SRAS enhanced its capacity by engaging directly with medical personnel. As a result, it is now in the process of accreditation as an ISO-certified entity. Unlike the preceding cases, this SRAS is heavily invested in skill standardization and seeks support from a private Catholic clinic which has engaged in accrediting its own SRAS. In this sense, Hospital C SRAS is building a management system which, in the head chaplain's words, will both increase its capacity for religious assistance provision and augment its legitimacy: "Doing this [certification acquisition] will enable us to do so much more, to become part of the hospital as a real service instead of being just a little bit inside"[42]. At the venue where this conversation was held, this is significant. In Fátima,

[41] Interview, former Health Minister
[42] Interview, Hospital C SRAS head chaplain

where Catholic chaplains regularly hold training sessions to which non-Catholic religious representatives are also invited, advances towards certification and skill standardization are seen as necessary change, but also a tool to refashion religious assistance into a form of medical care. Not all Catholic chaplains see this as necessary. The head chaplain of Hospital B SRAS speaks in a restrained tone when I ask him what he thinks about the Hospital C SRAS' proposal: "I'm not convinced at all about this, I mean it's certainly interesting but I just don't see how my work would be improved by all that management speak"[43]. The head chaplain of Hospital A SRAS, who engineered these training sessions, is more of an enthusiast. As a trained psychologist, he is conversant on psychiatry and bioethics; he sees the Hospital C SRAS as a progressive force in the religious assistance landscape: "This is the future for religious assistance. We may know a lot about bioethics and psychiatry or other support techniques, but recognition at that level is what we need"[44].

In Hospital C, because facilities are more concentrated and the Catholic chapel is located in a vantage point, SRAS members are able to walk freely throughout the facility. There is an interesting analogy between the freedom to walk around hospital wards and the ability to traverse organizational boundaries: one seems to be related to the other. It is also apparent that Hospital C SRAS deals with a heavier workload than both its Hospital A and Hospital B counterparts.

The facility is perceived as a benchmark for all other hospitals in the country as regards health and religion. The head chaplain has taken a lead role in debates over regulating religion in hospitals, within and beyond Hospital C, using his role as Coordinator of Hospital Chaplains at the Health Pastoral to advance a modern take on the role of religion within hospitals and the position of chaplains in relation to patients, staff and administration. However, the same individual also stated, in interview, that religious traditions needed to come together in order to "fight off the secularist agenda in healthcare (…), they [hospital administration] want to drive religion out of healthcare but we know that people, patients, do not want that"[45]. This subjective evaluation was neither agreed nor disagreed upon by other religious representatives. All interviewees agree on the role of this individual in both advancing the role of religious representatives in healthcare and the need for a religious coalition in order to protect access by religious traditions to hospitals. This is a significant development from traditional Roman

[43] Interview, Hospital B SRAS head chaplain
[44] Interview, Hospital A SRAS head chaplain
[45] Interview, Hospital C SRAS head chaplain

Catholic discourse on religion and health without actually questioning monopoly conditions in the religious field or the dominance of Roman Catholicism in healthcare.

The religious assistance regime in Hospital C stands in contrast to Hospital A and Hospital B. This is inferred, first, from the physical position of the Catholic chapel. When discussing this SRAS with one of the former Health Ministers interviewed for the purposes of this dissertation, an interesting anecdote was mentioned: "It is well known that, at the time of its construction, that hospital [Hospital C] had a predetermined allocation of physical space for prayer. Several government officials mentioned that no hospital should be without space for religion. Now I know that those were times of authoritarian rule and religion figured prominently in public space, but the fact is that very important persons in government did not want a repetition of the case of the first major modern hospital in Portugal, where religious symbols were not seen as desirable"[46]. The interviewee was unable to provide a source and desk research did not confirm this. However, when asked about this, the Hospital C SRAS head chaplain spoke of its veracity and linked it to the dominant settlement in the hospital: "Everyone knows about that story and says that nobody at the time or since wanted a hospital which had no sign of religion. It was never supposed to be a health factory or a cure factory. It was not built for that (…) I think our situation is different from some very large hospitals because people here value religion and chaplains, value the humanity of illness and the humanity of patients. It is a different culture and we see that (…)"[47].

At Hospital C, religious assistance is further removed from its sacramental origins than in the two other cases studied in this dissertation. As mentioned above, it is in the process of accreditation as a standardized service according to ISO norms. This stems from the support given by a number of Catholic clinics where religious assistance conforms to benchmarks and seeks to measure its impact. This was shown in detail at a training course, the reactions to which have been documented above: the Hospital A SRAS head chaplain saw it as a desirable development while the Hospital B SRAS head chaplain saw it cautiously. When asked about the potential of standardization to turn chaplains into spiritual managers, the Hospital B SRAS head chaplain stated: "I would not go that far. But this way of doing things, this propensity to conform… this is not really chaplaincy and we should be concerned". By contrast, the Hospital

[46] Interview, former Health Minister.
[47] Interview, Hospital C SRAS head chaplain.

C SRAS head chaplain sees these developments as both necessary and desirable. The Hospital C religious assistance regime factors into these differing outlooks on religious assistance development.

Instead of nurturing its connection to local parishes, the Hospital C SRAS is adapting to standardization pressure from within the hospital. The head chaplain is enthusiastic about adaptation but is also adamant about the need to maintain close ties to the theological underpinnings of chaplaincy. Paradoxically, his views on the requirements of religious assistance were comparatively closer to Christian theological readings of the human body and suffering than any other individual interviewed for this dissertation with an affiliation to a religious tradition. Instead of referring to the ministry of presence as a requirement for religious assistance, he speaks about suffering and solace in strictly theological terms. The insistence on these themes is important as it points to a contradiction between this perspective and the inward outlook of the Hospital C SRAS. The regime at SRAS reinforces pressure towards standardization – religious assistance as one support service among any other in the hospital – because it does not seek to evacuate religion, as seems to be the case in Hospital A. Instead, by coopting several insights from Christian theology into its daily operations, it forces the SRAS to adapt and differentiate itself from the Humanization Service, which it strove to establish. This is illustrated by the Humanization Charter, a policy innovation which is peculiar to this hospital. As a whole-organization commitment to humanize patient experience in its premises, its language is infused with Christian themes. It is an extended commitment by administration to put "Ill Persons" instead of "Illness Carriers" at the forefront of cure and care functions. During interviews where this was broached, it became clear that the head chaplain was at the forefront of its development and implementation. According to a member of the National Council for Ethics in Life Sciences, "efforts at that hospital [Hospital C] to humanize care and transform hospital life cannot be understood without the commitment of the head chaplain (…), the fact that he is probably more knowledgeable about the linkages between bioethics and Christian theology than anyone I know, the fact that he has been working for so long and that he has such good ties with a lot of important people in the hospital, that is important (…)"[48]. As a reputable expert in the ethics of death and dying, the head chaplain's commitment to humanization is commensurate with his ambivalence towards hospitals in general. This is also illustrative of the religious assistance regime at Hospital C. Because it forces the SRAS inwards without engaging in its exclusion from any organizational quadrant, instead including it in care

[48] Interview, National Council for Ethics in Life Sciences member.

to an extent unseen in the two other cases studied for this dissertation, the religious assistance regime results from the policy entrepreneurship of the head chaplain and an environment conducive to its transformation from a chaplaincy to a full SRAS.

As the religious assistance regime stimulates an organizationally inward-looking perspective, the strategic dimension interacts with this. The Hospital C SRAS is not as community focused as Hospital A and there is no established volunteer scheme, as in Hospital A, nor is there a dual perspective on community, as in the social/pastoral volunteer dichotomy suggested by the Hospital B SRAS. The Hospital C SRAS head chaplain does not seek to traverse organization-society boundaries as often or as forcefully as other chaplains because there are few costs on internal organization traversal. As mentioned above, freedom of movement through hospital wards is much higher than in Hospital A and higher than in Hospital B. The focus on community building is softer than in Hospital A, as is coalition building with other religious traditions. During the course of several interviews, religious diversity emerged as a politically-charged topic. When asked about the potential consequences of the 2009 Regulation on the monopoly of Catholic prayer space in Portuguese hospitals, the head chaplain reported the following: "Before 2009, I remember attending a meeting with several representatives, the Buddhists, the Hindus, the Muslims and some Evangelicals (…). We were to discuss what would happen if the first draft of the 2009 Regulation were to enter into force. Most of those people were very vocal about their rights and demand equal space for all religious traditions". At a later stage, the interviewee continued reporting and stated that "I was unable to control myself. I asked all of them if they really thought that they [the Portuguese State] would be up to providing equal space for each religious tradition, because I knew this was nonsense, everybody knows that only the [Roman Catholic] Church would be able to stop secularists from attaining their goals and drive religion out of hospitals. Even Evangelicals were silent by then. I suggested, you know, that they should stop claiming for their rights and start thinking strategically, so we agreed that the best way of going forward was to not touch upon the primacy of the Church and chapels"[49]. The political skillset of this chaplain is evinced by later developments. As mentioned above, both Hindu and Buddhist representatives are adamant about the significance of this individual's entrepreneurship, although their stance, if other interviews are to be trusted, moved dramatically towards accommodation of Catholic leadership in policy conflict. This confirmed by accounts of religious representatives in the aftermath of the 2009 Regulation. As mentioned above, the formation of a Task Force on

[49] Interview, Hospital C SRAS head chaplain.

Religion and Health was supported by several religious traditions under the leadership of the Roman Catholic Church. The Task Force was engineered by the Hospital C head chaplain and its core output, a handbook on the tenets of represented religious traditions on various healthcare issues, stems directly from the leadership provided by the chaplain and the accrued experience of Catholic chaplaincy. However, interviews show that the most relevant issue pertaining to the abovementioned Task Force is its invitation-only scheme. When asked about the context of its formation, Jehovah's Witnesses representatives stated that "we were well aware of its formation and took an interest in it"[50]. Jehovah's Witnesses' stance on blood transfusion are documented in the handbook. But this religious tradition was not invited to the Task Force. When asked about the details of invitations to the group, the Buddhist representative stated that "as far as I recall, invitations were issued by the Catholics and we did not make any suggestions"[51]. The Hindu representative confirmed this. However, when asked for confirmation, the Hospital C head chaplain stated that "all religious traditions interested in these matters were included in the process by their own avail". The process illustrates how the Hospital C SRAS exerted unparalleled influence both in the drafting of the 2009 bill (at least from 2007) and in the management of its consequences within the religious field. The dominant settlement remained in place and, according to all interviewees involved in the post-2009 Regulation events, this was a necessary and desirable goal, as Catholic leadership, which stemmed from its continued demographic prevalence, was essential in order to countervail secularist policymaking. The only significant leadership source within the pool of religious representatives charged with healthcare policy was, coincidentally, the head chaplain of the SRAS which had advanced further towards transitioning from a traditional chaplaincy into a full SRAS model.

The religious assistance regime in Hospital C is increasingly removed from the traditional chaplaincy model. This is an unpredicted consequence of organizational openness towards the role of religion and organizational recognition of its legitimacy. The head chaplain and his innovative approach to religious assistance would not have gained standing, in all likelihood, in a religious assistance regime which affords few opportunities in terms of quadrant traversal or policy influence. The Hospital C SRAS exerts influence on humanization and ethics; this is clearly linked to the stance of decision-making individuals and not clearly linked to the 2009

[50] Interview, Jehovah's Witnesses representatives.
[51] Interview, Buddhist Union representative.

Regulation on Spiritual and Religious Care: the head chaplain was able to mobilize significant resources in order to influence the final draft, both within the State and within the religious field. In order to amass these resources, individual capability must be factored in, but the organizational environment and specifically the religious assistance regime determined the position and capacity of a specific individual at the time. Again in contrast to the other cases studied for this dissertation, where agency was exerted either with a preference for investing in relationships outside the hospital but within the Roman Catholic community, or with a preference for investing in relationships within the hospital but seeks to form coalitions within the religious field, the Hospital C SRAS shows a different pattern. It is fully invested in developing relationships with professional groups within hospital boundaries. This is why its head chaplain and other staff members participate intensively in humanization efforts. It is not specifically invested in volunteer development as an interesting venture for its own purposes; however, in its potential for pastoral community development, the head chaplain referred to the volunteering effort at Hospital A as an important site, in parish-SRAS relationships or in importing parish priesthood into the hospital. Instead, it looks for broader policy intervention and entrepreneurship because the religious assistance regime has afforded its members a level of legitimacy and skill that is unparalleled in the Portuguese public hospital network. Instead of seeking coalitions with other religious traditions, it strives for leadership both within the Roman Catholic community and the religious field. This is shown by the numerous interviews given by the head chaplain to media outlets during 2007 and 2009 for the purpose of shedding light on the Regulation on Spiritual and Religious Care; no other religious representative was afforded as much media space and the only dissonant voice came from an Evangelical Alliance representative. In an interview, this representative stated that the Roman Catholic Church "had it coming, not that I want religion out of public space, but I think that there is too much insistence on the representativeness of the [Roman Catholic] Church and there is a need for balance". This statement was framed by a discussion on the reluctant support given by the Evangelical Alliance to the final draft of the regulatory bill which brought the Hospital C SRAS head chaplain into public salience.

6.2.3.3 Conclusion

Hospital C is furthest in the transitional process leading from traditional chaplaincy to a full SRAS model. Its focus is no longer in humanization, as the hospital itself has coopted humanization as a policy priority, has published a Humanization Charter and a White Book on Humanization, and operates an autonomous Humanization Service. The more advanced

organizational stage (as compared to the two other cases studied in this dissertation) stimulated a change in institutional focus towards therapy. The Hospital C SRAS seeks full accreditation as a service in order to consolidate its legitimacy and make gains in status and reputation. Thus, it seeks to transform chaplaincy into a modern spiritual support service. Because it focuses is on organizational standards, it is not specifically focused on community development or coalition building. Its members traverse internal boundaries – from cure to care quadrants – at low cost, as SRAS members use their legitimacy, status and reputation as resources for further entrenchment.

6.3 Comparative case overview

Hospital A, Hospital B and Hospital C are A1, Group III hospitals in the Portuguese health system terminology. They are, therefore, similar in organizational structure, budget, size, potential patient population, and staff size/distribution. In addition, these hospitals are located in urban areas where religious diversity is both higher than in other Portuguese regions and more similar between one another, as regards distribution of religious traditions, than between other Portuguese urban regions. Moreover, unlike other high-end public university hospitals, they are specifically 20th century phenomena. Their physical structure embodies medicine as a curative endeavor as it emerged in Portugal in the 1940s. These hospitals are research facilities where cutting edge science is taught and applied to an extent unseen in any other hospital in Portugal. The intersection between biomedical care, research and religion is important because, as Wendy Cadge suggests, the hybrid character of university hospitals further complicates exploration of the placement and displacement of religion in hospitals (2012). Attending to a diverse student population, the unpredicted consequences of knowledge creation and transfer as inherent to universities make this an important case feature. This, more than other features of university hospitals, is the most important contextual factor in discussing religious assistance within hospitals.

Lower-ranked medium-size (A2 or B2, Group I or II) hospitals are generally located in smaller urban settings and their organizational challenges are significantly different from those facing larger hospitals: budgets are lower, as is the number of resident specialists, but demand remains high, as these hospitals provide care for comparatively isolated and vulnerable individuals. As an important detail to this study, rural residents are older, thus increasing the probability of hospital visits and stays, and are more likely to state a deeply religious outlook on life and health, thus increasing the probability of, at some point in hospital stays, requesting spiritual

care (generally, by a Roman Catholic priest) of the sacramental sort, instead of wishing to speak about general concerns about mortality and the human condition. Religious assistance in these organizational contexts continues to be deeply connected to its religious underpinnings, as opposed to the fluidity observed in the three cases studied for this dissertation. During a training course for Roman Catholic chaplains, an elderly chaplain and his assisting staff, working at a Catholic Church-owned hospital, stated that their duties were entirely related to sacraments – the ministry of presence, as formulated by Sullivan (2014), was not prevalent. More precisely, the requirements for chaplaincy in these facilities do not seem to entail skilled management of religious diversity in religious assistance rosters and the needs of these patients tend to pertain to end-of-life sacraments, instead of continued psycho-social support which relies on the employment of a set of techniques which chaplains in these contexts do not necessarily have. These are minimal requirements for SRAS staff working in the three cases studied in this dissertation. These include burnout prevention, supportive listening and enhanced relationships with nursing staff. An assistant at Hospital B reports that "preventing burnout is a very important issue for us. Not only for ourselves, because our work is very demanding, but also because we see the toll it takes on medical staff, especially younger people"[52]. The interview went on to include several reports on suicide rates among younger doctors: "We do not limit our work to pure healthcare. I personally work with the [Roman Catholic] University Pastoral Committee. The demands of healthcare work for young doctors and nurses are too high. Sometimes, we need to concern ourselves at least as much with these people as with patients, even those in end-of-life situations"[53]. In contexts where chaplains and other religious representatives need to attend to diverse populations, employ more modern support techniques and engage in less sacramental action, they also need to master the usage of technical idioms and adapt to the rhythms of medical treatment. According to the head chaplain of Hospital A, "we tend not to use heavily religious terms because our aim is to provide solace. We are of course ordained priests and our work is sacramental and pastoral in a very specific sense, but I may have to provide support to people who are Catholics and need to talk to someone who is not just in the business of providing medical care. Our work is about care and solace, not cure in a strict medical sense. I have learned how to speak to people who may come from a Protestant Church, who may be Islamic [sic], even atheists who find themselves in need of an attentive ear and a softer touch"[54]. In this sense, chaplains at each of these hospitals, as religious

[52] Interview with staff assistant, Hospital B University Hospital SRAS
[53] Id.
[54] Interview, Hospital A University SRAS head chaplain

representatives accredited to each institution, are embedded in the care function of hospitals but extend its capacity, according to their perception, because they are both within and outside the hospital. They are never fully embedded in the operational flow of hospitals, but are also not oblivious to their environment. According to a representative from the 7th Day Adventist representative, "When we are called in, we seek to hear and be as quiet as possible, as non-judgmental as possible (…) people in these situations [bed-ridden patients] have no patience for people who talk a lot about religion. If it comes to religion, we are supposed to talk about it. But in my experience religious assistance in hospitals is more about presence than about talking."[55]

6.3.1 A characterization of chaplaincies in Portuguese public hospitals

As of 2014, there were 239 registered Roman Catholic healthcare assistants. Of these, 235 were male, 4 are female. 173 assistants were stationed at healthcare institutions; 131 of those were stationed at hospitals and 42 are stationed at local health centers.

Private institutions comprise parish community centers, Catholic-sponsored clinics and retirement homes.

114 of those worked in public hospitals, 14 of which are large-scale, Group C hospitals. Geographic coverage is wide and covers the entire spectrum of hospitals in the Portuguese Health System.

Table 13. Private/Public Distribution of Roman Catholic Chaplains

	Local Health Centre	Hospital	General Total
Private		17	17
Public	42	114	156
Totals	42	131	173

Source: Portuguese National Health Pastoral Listings (2014)

Of those 114 public hospitals, 99 reported one religious assistance staff member. In single-member religious assistance services, all were male and ordained priests. Female religious assistance staff members and deacons are second staff members. 12 hospitals show a two-member religious assistance service. Finally, three religious services report four members. These are the three SRAS studied for this dissertation. These do not include non-Catholic staff members or assisting professional staff.

[55] Interview, 7th Day Adventist representative.

6.3.2 Structural change in the Portuguese hospital sector: examples from three cases (2000-2010)

A transition into scalable organizational structures, which occurred between 2000 and 2010, allowed for a degree of streamlining in the Portuguese Health Service. This transition resulted in three adaptive developments.

The Portuguese health system is now more reliant on hospitals: its decision structures are defined around core institutions and lower-ranked institutions, organizations and individuals show lower levels of decision-making power. This is consequential to religious assistance because it is not particularly legitimate within the organizational structure of hospitals: chaplains, even where they amass commensurate levels of organizational influence, are always in need of negotiating around limits imposed by the hierarchy of cure and care – religious assistance stands at the bottom of the decision-making chain and chaplains must report to nurses and doctors. Centralization thus entailed a decrease in the importance of religious assistance because its baseline position was far from consolidated or legitimate enough to maintain with consistency.

Levels of organizational differentiation and articulation between healthcare entities have also been enhanced. Hospitals are driven to become more specialized in certain areas of medical expertise and are unlikely to nurture those medical disciplines that are likely to support religious assistance. Internists, for instance, are driven to the margins of hospitals because internal medicine is seen as belonging in other healthcare organizations, namely lower-ranking health centers and lower-level hospitals. High-end hospitals, such as the cases studied in this dissertation, are likely to maintain a staffing policy which is invested in technically demanding, expensive treatments which require monitoring by highly specialized doctors and nurses. Each institution is pushed to show how its contribution to the overall health provision capacity makes it ever more valuable. This development occurs in tandem with a paradoxical mutation in the regulatory framework. It is converging towards detailed guidelines and benchmarks which share the goal of streamlining organizational activity along managerial lines. In 2005 and 2009, all public hospitals were mandated to implement managerial reforms and converge into a public enterprise model. Case-based care services in hospitals need to adapt to these regulatory demands to a greater extent than parameter-driven cure services. In this context, religious assistance, which is based on an individual, case-based philosophy of care, has had to adapt to a greater extent than any other service. The 2009 Regulation on Spiritual and Religious Care is an attempt to streamline religious assistance into comparable services across every

Portuguese public hospital. It provides for specific guidelines with regard to payment structures, as religious assistance staff is no longer paid on the basis of contractual agreement but on the basis of precarious arrangements. This creates a three-fold pathway for religious assistance staff members. Older Roman Catholic chaplains remain employed as public workers; younger Roman Catholic Chaplains are to be employed under precarious terms; religious representatives from any non-Catholic tradition continue to not be paid. The 2009 Regulation, which started out as an attempt to drive religious assistance out of hospitals, thus resulted in the reinforcement of traditional actors in religious assistance services and in the reinforcement of the dominant settlement in religious assistance. There is no case in A1, Group III hospitals where religious assistance services are managed by either a younger Roman Catholic Chaplain or a non-Catholic religious representative. In each of the three cases studied in this dissertation, religious assistance services were managed by Roman Catholic chaplains employed before 2009. However, even in the context of increasing convergence in organizational responses and institutional arrangements, these continue to vary to some extent. Religious assistance, in particular, caters to needs which are not easily streamlined: one of the fundamental tenets of its function in hospitals is to provide for case-based care which does not rely on tested, medically accepted diagnostic techniques, instead relying on the skills of each permanent staff member – i.e. the resident head chaplain and his assistants – to identify persons in need, to respond to requests for spiritual and religious assistance and to connect with nursing staff which serves as a core link between patients and religious assistance staff members. Religious assistance became significantly more regulated in 2009, but these core features did not change significantly. This may factor into the common reporting by all interviewees of these as core features of their activity and little to no impact by regulatory change. However, each of these services has developed differently according to its organizational environment and resources available to head chaplains.

While religious assistance was indirectly affected by transformations in the organization and management of hospitals, it has also developed divergent patterns across each of the three cases studied in this dissertation which are not linked to those transformations. Variance was observed at the level of demand for religious assistance, according to interviewees in Hospital C and Hospital B, because religious diversity increased at the same time that levels of expressed religiosity did not decrease in a significant way and the need for humanization through case-based care, namely spiritual and religious assistance, maintained levels previous to 2009. This is, according to both chaplains employed in Hospital C and Hospital B and religious representatives designated for healthcare support by their communities, because high-level

hospitals have become increasingly centered on their cure-related performance indicators and have relaxed humanization efforts. This is likely to be a trend across Portuguese healthcare, which, as a system, has become increasingly strained by management requirements and fiscal constraints which drive resource distribution to those functions that assure dominant groups in hospitals a maintenance of status and, at the same time, are perceived to be those most valuable to the hospital in terms of its access to budget outlays. Religious assistance, because it has no measurable impact on the cure functions of hospitals, is unlikely to gain access to those resources. Employed Roman Catholic chaplains may sit at ethics committees in each of the three cases studied in this dissertation, but they face challenges as regards their access to higher administrative echelons. The exception, Hospital C, is due to the skillset and resources available to the head chaplain, as detailed below, and also because the distinctive strategy towards humanization as a complete organizational goal has transformed this hospital and is conspicuously referred to by former Health Ministers, the Catholic Health Pastoral chiefs and four religious tradition representatives[56] interviewed during the course of the research process for this dissertation.

6.3.3 Convergence and limited divergence in religious assistance

In this context, there is significant convergence and limited divergence in religious assistance patterns across each of the three cases. This points to the effect of regulatory constraints and the contextual relevance of the 2009 Regulation on Spiritual and Religious Care. All interviewees directly involved in the management of religious assistance in hospitals mentioned these effects, but followed these remarks with observations on the degree to which humanization efforts, particularly the institutionalization of humanization policies, protect religious assistance from threats to its significance in the wider context of the hospital. Hospital C representatives mentioned issues of humanization and the medicalization of care as significant factors in determining the pattern of religious assistance. This points to an important question in this study. To what extent do State-religion relations impact religious assistance services? According to interviewees, when asked about the significance of these arrangements, effects are limited. However, when asked about the 2009 Regulation, their responses varied. Macro-level constructs, such as State-religion relations or corporatist modes of intermediation do not seem to play a role in hospital daily lives, but their importance is presumed at higher

[56] The four representatives are the Methodist Church representative, the Baha'i representative, the 7th Day Adventist Church representative and the Hindu representative.

policy levels, as stated by the Hospital A head chaplain: "That [State-Church relations] has no bearing on how we live in the hospital. Politics do not play a role; here, we are concerned with patients. I leave those things to politicians from both sides [State and Church]"[57]. Indeed, the State and the Church are themselves constructs exerting differential impacts in daily hospital operation and their importance and impact was never fully recognized by interviewees or, for that matter, official documents.

It is now consensual that the monopoly of the Catholic Church on faith-related space and practice in hospitals does not respond suitably to patient needs, especially in a context where intercultural practice is in the process of mainstreaming into public service provision, following European Union-related convergence on shared values and anti-racist/anti-xenophobia policy. The emergence of culturally-sensitive public service provision is related to this discursive shift, and both the State and the Church had to adapt. The Regulation on Spiritual and Religious Assistance in Hospitals entered into force in 2009 and is detailed and discussed elsewhere in this study. During my interviews, representatives apart from the Evangelical Alliance seemed oblivious to the process. While the interim President of the Commission for Religious Freedom (a former president of the Evangelical Alliance) publicly expressed his reservations about perceived vagueness in the final bill, other representatives preferred a more cautious approach, either refraining from making open statements on the document or abiding by the principle of representativeness and seemingly accepting Catholic oversight.

The current regime accommodates difference via official accreditation to all spiritual assistants from registered religious communities and has partially disenfranchised Catholic chaplains, who were, up to 2009, public workers and benefited from a regime of exception. However, the concentration of migrant communities – who might request non-Catholic religious assistance – and subjectively non-believing people – those most likely to not request assistance at all or to request non-religious spiritual care – in large urban centers such as those where the three cases are located may provide an initial explanation: pressures towards the supply of pluralized services emerge only in hospitals where the perceived need for culturally or religiously sensitive arises and is seen as important.

[57] Interview, Hospital A University Hospital head chaplain.

6.3.4 The impact of regulatory change on religious assistance

The 2009 Regulation on Spiritual and Religious Care forced chaplaincy at public hospitals to enact a number of changes in their operations. This is illustrated by the common adoption of regulatory standards, which were agreed by most chaplains in charge of significant religious assistance operations. These include all three cases studied in this dissertation. Regulatory standards conform to the 2009 Regulation and mention the 2004 Concordat as a condition for continued exceptionality enjoyed by the Roman Catholic Church, just as other religious traditions' positions are to be regulated under the 2001 Law on Religious Freedom. In order to further establish its role as a common regulatory standard with specific provisions on quality assurance, the standards defined by the European Network of Healthcare Chaplaincy in Turku, Finland, in 2002, form the core framework of religious assistance in the post-2009 period. For the purposes of this dissertation, four of those benchmarks merit further discussion:

1. To assure support to patients through empathic listening and customized spiritual and/or religious support;
2. To promote and arrange meetings, lectures or other cultural events conducive to a healthy and health-promoting spirituality, namely reflecting upon the spiritual bases of suffering, illness, death and life;
3. To promote respect for different traditions, cultures and faiths, as well as to sensitize [the hospital community] to the need for strategies towards the protection of patients from the imposition of unwanted healthcare or proselytism;
4. To arrange for communication channels between the SRAS and religious traditions in order to promote spiritual and religious provision to patients in full respect of their customs.

These benchmarks show two common themes: the juxtaposition between spiritual and religious care, in the wake of regulatory change which promoted spirituality as a byword for religious belief and practice, and specific provisions on the mainstreaming of religious diversity into religious assistance in hospitals. As argued throughout this dissertation, these transformations point to regulatory pressure towards increased attention to religious diversity as a core societal issue to which the chaplaincy model was no longer responding to. However, it is also relevant that these standards continue to point to a dual regime which enforces Roman Catholic exceptionality: in mentioning the 2004 Concordat and the 2001 Law on Religious Freedom,

these regulatory standards maintain the dominant settlement in the religious field and transpose it into the religious assistance regime in each hospital. The question then becomes whether SRAS in each hospital is becoming a strategic action field and whether the adoption of common standards, underpinned by the dominant settlement in the religious field but opening opportunities to challengers, forces convergence. This is further established in the regulatory standards as SRAS coordination is no longer to be appointed by any religious authority, as opposed to the 1980 regime. Instead, SRAS coordinators are to be appointed by hospital administrations, which must consider representativeness. In this context, representativeness forces hospital administrations to designate Roman Catholic representatives in any given situation, as Catholicism continues to be dominant throughout Portugal. Criteria connected to representativeness have been questioned by secular and atheist movements in Portugal, in addition to vocal opposition of their usage by the interim President of the Commission on Religious Freedom. These oppositional perspectives construe the Portuguese Constitution as fundamentally opposed to giving any credence to religious representativeness as a criterion for appointment or decision-making. The post-2009 regulatory standards go on to provide detail on the duties of SRAS members regarding State confessionality, as staff members and non-staff accredited religious representatives must respect "State non-confessionality". When asked about the contentious character of these provisions and the potential for conflict written into the document, Roman Catholic Church-affiliated interviewees did not answer. Religious representatives involved in the Task Force on Religion and Health maintained a consensus-driven line of reasoning: "without him [Hospital C head chaplain] and the Catholics we wouldn't be able to have a voice over how things are done"[58]

The existence of common standards deriving from an overarching regulatory regime thus points to isomorphic pressures and it was expected that, as research started more than two years after its enforcement, convergence was to be observed. It was expected that, given that regulatory constraints are expected to be enforced to a greater degree in larger organizational contexts, the three cases studied in this dissertation would show significant convergence. However, as detailed below, regulatory constraints have had unforeseen consequences. In Hospital C, given the political prominence of the head chaplain in the policy process, adaptation was not enforced through regulatory change because religious assistance was already in the early stages of transitioning from a chaplaincy model to a SRAS model.

[58] Interview, Buddhist representative.

Hospital A lacks such individuals. Before 2009, the religious service of Hospital B started its operations, initiated by the team of Catholic chaplains certified as "spiritual assistants", who invited priests from local communities to provide part-time assistance. Basic knowledge of regulatory demands was very high and adaptation efforts began in late 2008, before the 2009 Regulation entered into force. These included evangelical churches serving migrant communities living within the reach of the hospital, and other more established traditions. This service operates without much regard for legal provisions or limitations; instead, it built upon interpersonal trust-based networks, both horizontal and vertical, as the administration was assuaged about the need to offer such services. Nevertheless, facilities continue to provide a single Catholic chapel and plans for multi-faith prayer rooms do not exist.

Hospital A operates a service which has to deal with a distrusting administration and some distrusting staff clusters, according to the SRAS head chaplain and other religious representatives. The Jewish representative recounted an anecdotal but important incident as he was called for burial rituals in the hospital morgue: "The coroner was extremely unpleasant and demanded to know who allowed me to enter premises (…), I had to become aggressive and state that I had been called by the late person's family and that I was legally allowed to perform initial rituals. Being a medical doctor myself, I found the whole situation absurd and uncomfortable"[59]. The Protestant representative also mentioned that the strategy of impersonating a Catholic remains a go-to strategy when reception desk officers seem reluctant to allow access even when the certification document is presented: "(…) nothing has changed extensively there [Hospital A], we still need to fake our identities and say that we are priests even after presenting a certificate that allows us entrance into hospital premises. The problem, for us, lies more with administrative staff than nurses or physicians (…), this is not something you solve through laws and regulations, it is about education and cultural awareness"[60]. The Sunni and Ismaili representatives reported no incidents in conducted interviews. When asked for a follow-up on their reporting of no incidents, there was no mention of difficulty in access to hospital premises. As mentioned before, registration at reception desks is mandatory. The status of Muslim representatives' access to hospital premises was not fully determined, but desk research shows that institutionalized Islam in Portugal aligns closely with those actors in

[59] Interview with Lisbon Jewish Community representative.
[60] Interview with Protestant Alliance president.

the religious field that seek stability, which could explain the inexistence of reported incidents in interviews.

The impact of regulatory regimes may therefore be more important than stated by interviewees. The Portuguese Constitution protects citizens from mandatory disclosure of religious affiliation. Moreover, rulings over personal data and informed consent further shield patients from undue interaction with non-clinical staff. Patients must voluntarily inform medical staff of their requisition of spiritual assistance. Spiritual and religious assistants then must request formal authorization from clinical directors and hospital administration in order to access those patients. Before 2009, chaplains would be implicitly able to use hospital speaker systems to call for mass or use their free-roaming capacity within hospital premises in order to gain access to hospital wards. After 2009, assistant access to hospitals was increasingly regulated: Roman Catholic priests must present certification in order to gain access to wards. But access for that segment is usually easier than for other religious representatives. The Hospital A mentioned the US regulatory regime again in this regards: "In the United States, none of these [regulations] are needed and everything works. There are just too many rules and we could arrange things without interference".

Representatives from all religious traditions emphasize the need to advance human-centered or holistic care[61], openly as a strategy to reposition religion and religious representatives in medicalized environments, where arguments based on scientific inference and management-centered hospitals have gained prominence over the years. However, the recent interest in holistic care in hospitals has provided an opening of the opportunity structure for religious representatives to reassert their roles in hospital settings. Interestingly, the absence of non-Christian chaplains at public facilities is dealt with via some of the same tactics used before 2009: interpersonal trust networks and requests to the incumbent priest.

6.3.5 From chaplaincy to spiritual assistance

Religious and spiritual care is thus deeply embedded in the overarching history of healthcare, although power struggles have shaped paths and conditioned access conditions to religious

[61] Indeed, "human-centeredness", "holistic care" and tropes linked to recent documents by the WHO and, although in a different vein, New Age discourse, is one of the main angles used by religious representatives in order to justify the place of religion in seemingly secular, modern, scientism-infused facilities such as hospitals.

communities seeking to care for their constituents. However, the dominance of the Catholic Church is evident in more than legacies or symbolic monopolies. Since there was no official accreditation procedure, non-Catholic spiritual assistants had to request the aid of resident chaplains in order to access patients. The 1980 regulatory framework stated that Catholic chaplains were hospital personnel, fully paid by the State, and should facilitate other traditions, but there were no specific provisions for the pluralization of hospital space. More than 30 years later, desk research shows that most public hospitals continue to provide a single Catholic space and one or more Catholic chaplains. Currently, while discretionary power accorded to chaplains has been largely let go of, the "law", namely above-mentioned regulation and enforcement by the Commission for Religious Freedom, the corporatist body working as the regulatory agency for the religious field, has sometimes to be called upon in order to facilitate patient access to religious minority representatives. But it is no longer provided for by the legal framework; indeed, the Hospital A chaplain and other religious representatives (Protestant representatives have been especially vocal in stating that even Catholic representatives sometimes face difficulties regarding patient access. These representatives also assert that constructs such as "State-Church relations" or even "confessional representativeness" are of little consequence in the daily operation of belief within hospitals. It is questionable whether these statements represent reality, by the very nature of spiritual care structure in Portugal and the gatekeeping role of Catholic chaplains. But they are analytically interesting statements precisely because of their counter-intuitiveness. Patient access, according to all interviewees, is much more related to relationships with hospital administrations (raising the issue of professional groups, the influence of coalitions and the importance of *ad hoc* entrepreneurs, as I shortly emphasize) and administrative personnel, who may function as *impromptu* and sometimes quite literal gatekeepers.. Indeed, the State and the Church are themselves constructs exerting differential impacts in daily hospital operation and their importance and impact was never fully recognized by interviewees. Analysis of the 2009 Regulation and a comparative assessment of spiritual care regimes in similar hospitals show how important it is to understand linkages between policy and daily-life dimensions.

In 2007, Church and State officials agreed on the need for regulating the 2004 Concordat. After the 2001 Law on Religious Freedom, the ruling framework was legally incoherent and, most importantly, it was widely recognized as anachronistic. Portuguese society was no longer the monolithic Catholic bloc crystallized by the 1940 Concordat nor by the 1975 *détente* between the newly democratic polity, anti-religious revolutionary forces and the Church. The 1980 Regulation on Spiritual Care in Hospitals was seen as dated. The dual pressure of secularization

and pluralization connected with the emergence of parliament-seated secularist groups with enough clout to propose a Law on Religious Freedom which created the conditions for the breakdown of the Catholic monopoly and the need to reform State-Church relations. After 2001, a Committee on Religious Freedom was created. This is a venue where State perceptions on which community by what standard is legitimate and deemed politically legible (Scott 1990; Laurence 2012) became clearer. By 2009, it was clear that the monopoly of the Catholic Church on the usage of faith-related space and practice in hospitals was not adapted to current societal needs, especially in a context where intercultural practice was in the process of being mainstreamed into public service provision, following European Union-related convergence on shared values and anti-racist/anti-xenophobia policy. The emergence of culturally-sensitive public service provision is related to this discursive shift, and both the State and the Church had to adapt.

6.3.6 The policy process of Decree-Law 253/2009

The process of draft and approval of Decree-Law 253/2009 was nevertheless surprisingly riven with contradictions and conflict; with the exception of Catholic and Seventh Day Adventist representatives, interviewees acknowledged conflict, but were surprised at the adamant position taken by the Church when the subject was broached. Interviews show that the Portuguese State and Roman Catholic Church clashed during the period; intra-State conflict was also reported by high-level officials. While the State regarded a level playing field as a necessity arising from legal provisions and distributive justice, the Church regarded such understandings and goals as colliding with both its continued representativeness and the need to smoothen a transition into a plural regime as much as possible. The Church argued that, by dismantling the former regime, the State would not be aiding so-called "affirmative action" so much as disenfranchising that tradition which most Portuguese people held up as its own[62]; leveling the playing field should, again according to the Church, be about extending rights to all instead of eliminating them.

The Church representative in the process, also the Catholic chaplain at Hospital C and the national coordinator of the Health Pastoral Commission of the Portuguese Catholic Church,

[62] The issue of size and representativeness was brought up by all interviewees and the need to recognize the Roman Catholic Church for its historical importance and societal representativeness was also asserted, with the significant exception of two Protestant representatives.

heavily criticized, as confirmed by interviews with religious representatives and news reports, the then-incumbent Health Minister, his successor, and the State representative in charge of politically driving the process, the Health State Secretary. In the midst of an unexpectedly protracted process, the responsibility for drafting and approval of the Regulation was removed from the Health Department by the Prime-Minister, who took up the issue himself in an unexpected move. Changes were drafted into the Regulation; its final version is, according to one interviewee, more in tune with Church demands than the first draft: "It seems obvious to me. Have you read it? I read the first draft and it was not good, at least not good for the Church. They fought hard to change the first draft"[63]. During interviews, representatives apart from the Evangelical Alliance seemed oblivious to the process and the Hospital A SRAS head chaplain expressed indifference towards the political underpinnings of the whole process. While the interim President of the Commission for Religious Freedom (a former president of the Evangelical Alliance) publicly expressed his reservations about perceived weaknesses in the final bill, other representatives preferred a more cautious approach, either refraining from making open statements on the document or abiding by the principle of representativeness and seemingly accepting Catholic oversight. According to the Methodist representative: "It would be useless to dispute Catholic dominance. Portugal is historically Catholic and that's it. What we do instead is try to work out how to cooperate with them, because it helps us"[64]. The current regime accommodates difference via official accreditation to all spiritual assistants from registered religious communities and has, to all intents and purposes, disenfranchised Catholic chaplains, who were, up to 2009, public workers and benefited from a regime of exception. The question of whether monopoly conditions were broken remains. However, the concentration of migrant communities – those most likely to request non-Catholic religious assistance – and subjectively non-believing people – those most likely to not request assistance at all or to request non-religious spiritual care – in large urban centers may provide an initial explanation: pressures towards the supply of pluralized services emerge only in hospitals where the perceived need for culturally or religiously sensitive care arises and is seen as important.

The Hospital C chaplain referred to his role in outlining the legal bill while providing context on the advanced stage of humanization efforts in the hospital. His Hospital B counterpart emphasized the role of the legal bill in enforcing necessary changes with regard to his work

[63] Interview, former Health State Secretary.
[64] Interview, Methodist representative.

and his position within the hospital. Their Hospital A counterpart kept a significantly more circumspect reading of the effects of the legal bill, as it did not seem that the hospital adapted to regulatory changes. It may be inferred from these insights that religious assistance services are supported by a broader religious assistance regime which is defined in the legal bill. It then interacts with a number of contextual factors, namely those related to the skillset and resources available to influential individuals, particularly head chaplains, levels of religious diversity and their associated demand for differentiated religious assistance, the existence of humanization policies in the hospital that provide additional legitimacy and resources to religious assistance as a form of care which is not necessarily measurable or relevant to patient inflow/outflow ratios but is nonetheless important to hospital decision-making structures.

This discussion is relevant because it allows us to propose a differentiation between two components of religious assistance: the service component and the regime component.
The religious assistance service comprises all activities performed with the goal of providing care with explicit or implicit spiritual or religious bases. These activities comprise traditional religious services and rituals, informal consults provided by religious assistance service staff members in hospital wards or in the existing work stations for religious assistance and events arranged by religious assistance services.

The religious assistance regime comprises the framework of religious assistance in the hospital and the opportunities and constraints which nurture or limit the development of religious assistance in hospitals. Specifically, these are the negotiated local orders (Lipsky 2010) of religious assistance in hospitals. Religious assistance regimes are the core component of religious assistance because services are provided on the basis of regime features. Chaplains and religious representatives are constrained by these frameworks in their relationships with nurses, doctors and administrative staff. These frameworks also determine the ability of religious assistance staff to traverse the boundaries of each hospital quadrant – how these individuals are able to contact and influence the care, cure, command and community quadrants specified in Chapter 4. Ability is a result of each religious assistance service pooled skillset within the context of the religious assistance regime. As shown in case descriptions, religious assistance services are as different from each other religious assistance regimes allow.

CHAPTER 7: Analysis and discussion of religious assistance

In the previous chapter, it was shown that religious assistance in Portugal is a particularly complex organizational problem for both public hospital administrations and SRAS members. This is the case in three of the largest public hospitals in the country. In the healthcare strategic action field, religious traditions have come to hold a fragile position from a starting point of dominance; healthcare is one of the paramount issues for religious belief, practice and ritual. The emphasis placed on the public availability and public-centered production of healthcare poses additional problems to religious assistance, as these institutions enforce an environment where, at least, no given preference for any religious tradition is stated. This is a form of organizational secularity, which comprises all institutional and organizational arrangements built towards the prevalence of secular categories and the evacuation of inequality on the basis of religious preferences. In the case of hospitals, this includes biomedical treatment, which theoretically assigns equal value to human life and equal focus on illness, regardless of whom is carrying. Furthermore, religion faces an additional problem in contesting biomedicine. It is the current dominant settlement in healthcare organizations which specialize in acute care, such as hospitals.

Conceptualizing religious assistance as non-medical care is an important step in placing it in hospitals without resorting to a debate on the uniqueness of chaplains in these institutions. Chaplains and religious representatives are organizational field members. They are goal-oriented and they pursue strategies in order to attain survival and development. They seek to improve their position within the hospital, the Catholic community and the religious field via entrepreneurial action. They do so on the basis of sense-making and meaning-making processes, which they engage with social skill. In this sense, these actors are no different than physicians or nurses; they are challengers because they do not abide by the dominant biomedical settlement. In effect, these individuals perceive the stakes to be about the primacy of religion and how it defines human nature; in hospital settings, the biomedical settlement defines religion out of the picture by constraining any non-material interpretation of human nature to the realm of speculation. These individuals perceive this not only as threatening to their belief systems, but also – and most importantly – as erroneous. In their view, human nature and human beings are fundamentally non-material and it is the spiritual nature of human beings which holds the key to good health. Chaplains and other religious representatives perceive this as the key challenge with regard to the position of religion in hospitals. It is not only about the added value of religion in healthcare settings, but also about the therapeutic

effect of spirituality, which is seen by chaplains as a no less important factor in care and cure than any given biomedical treatment.

Their skills are not standardized and their perceived role as religious representatives prevents gains in status within the hospital, but they are also not challengers in the usual field-theoretic sense. Existing, regulated SRAS tend to support the dominance of medicine in hospitals. Their written statutes, which scale the dominant settlement in the religious field – Catholic exceptionality – and in the healthcare policy field – Catholic chapels in hospitals – to SRAS in individual hospitals, mandate SRAS members to be fully abiding of medical decisions.

7.1 Transitioning from chaplaincy to religious assistance

Traditionally, the provision of religious service in any non-religious organization is termed chaplaincy. The term is frequently linked to Christian theology and practice: indeed, the oldest accounts of chaplaincy report to the Frankish armies and the presence of Catholic priests who provided support to military personnel (Risse 1999; Swift 2009: loc397-840). Moreover, the modern concept of chaplaincy is frequently connected to ideas of presence and what some theologians term "visitation". Chaplaincies are thus places of religion and, more fundamentally, places of healing. The history of chaplaincies supports the claim that these institutional arrangements are poorly suited to proselytism: as Christian theology is particularly sensitive to human wholeness, suffering and redemptive pain, it is also distrusting of converting patients who are in need of support. While some priests from institutionalized traditions may perceive this as an irrelevant preserve of patient integrity, interviews for this dissertation show that chaplains in each of the three hospitals studied for this dissertation distrust conversion in these contexts, preferring to see their function as supporting and care-focused. Representatives of many religious sensibilities or affiliations keenly discuss these topics. There is some consensus on the Christian origins of chaplaincy, which implies the displacement of religion into non-religious organizational settings. Even in hospitals under the management of Roman Catholic orders, religious rituals are embedded in health-related practice: as far as chaplaincies are concerned, religion is never the dominant trope, but only its backdrop. However, religion continues to be the chaplaincy's central claim to relevance.

What might suggest a transition from chaplaincy to a SRAS model? The emergence of religious diversity and the entrenchment of secularity are two likely candidates. The impact of these processes on the provision of religious services in non-religious organizations is currently the

object of increasing discussion. However, as shown in this dissertation, chaplaincies may transition into SRAS for unexpected reasons. In Hospital C, the transition did not occur post-2009; instead, it started before and accelerated after the entry into force of the 2009 Regulation. In Hospital A, where the head chaplain is an accredited psychologist and has taught graduate classes on Bioethics, the SRAS has had to resort to community development in order to survive. This is a paradox, but it is also arguable that, without the presence of a trained clinical professional, the Hospital A SRAS would be even less integrated into the organization.

Chaplaincies existed (and continue to exist) in contexts where the religious field is characterized by very high asymmetry between incumbents and challengers. In Western European countries, Roman Catholicism was monopolistic to varying extent, depending on geography and polity structure. After the Reformation, monopoly conditions were broken in several nascent national polities and cleavages became very pronounced. Religious diversity within Western Christendom became politicized. Chaplaincies continued to provide service to their constituents as most remained within a Christian framework; in remaining Roman Catholic monopolies, the ongoing provision of social welfare by the Roman Catholic Church ensured the continued dominance of a certain model of chaplaincy. The emergence of secularity, as modern State-building took place, occurred in parallel to structural change in the religious landscape of several European contexts. Secularity is arguably a product of emerging religious diversity, but the point here is that secularity interacts with religious diversity in order to make the chaplaincy model and the role of the chaplain increasingly questionable. Religious assistance becomes a more rigorous description of what the provision of religious services in non-religious institutions entail than chaplaincy. Chaplaincy provides a historically accurate but politically inaccurate description of what was at stake when the chaplaincy model was seen as no longer providing services which respected an emerging ethos. Liberal pluralism and secularity pressure the traditional model of chaplaincy and chaplain roles into a shift towards religious assistance. As religious diversity turns into a politically sensitive question, based on migration patterns and change in the religious field, the provision of religious service in non-religious institutions is best described as religious assistance: while providers continue to cater to the needs of their constituencies, as dominant religious traditions did not relinquish their positions, these providers had to consider four problems. First, non-religious organizations became increasingly defined by their own local, negotiated secular orders. Second, these secular orders were built along liberal democratic principles intended to assuage claims by many societal interest groups. Third, they had to face the problem of catering to their

constituencies without endangering their position in local secular orders, which mandated egalitarian provision.

Fourth, they had to face the challenge of attending to the religious needs of individuals which belonged to other religious traditions. Table 8 shows a comparative table on the typical characterization of 1980s chaplaincy and 2000s SRAS models in Portugal. It compares the 1980 model to its 2009 counterpart and shows how the SRAS model defined in the 2009 Regulation departs from the chaplaincy model defined in the 1980 Regulation in most categories. Local order importance pertains to the role of the organizational environment in which religious assistance is provided. In 1980, chaplains were paid by public outlays but were not beholden to any form of public supervision; instead, they were designated by Bishops and were to respond to ecclesiastic hierarchies. In 2009, as shown in Chapter 6, hospital administrations are invested with the supervision of religious assistance, in accordance with regulatory demands.

As regards representation, the 1980 model did not make any formal provision for the representation of religious traditions in the hospital. Instead, it endowed the head chaplain with discretionary power over access to hospital premises, even though access depended on registration – as reported above, Roman Catholic chaplains acted as gatekeepers until the 2009 Regulation provided other religious representatives with formal mechanisms for their autonomous access to hospital premises. It remains, however, that access is still dependent on patients informing hospitals of their request for religious assistance (other than Roman Catholic). It was reported in interviews that Catholic chaplains, because their access to hospitals is not predicated on these rules and is continuous, have more information regarding the religious affiliation of patients and function as relays to their peers. This, in effect, was one of the factors which led to the establishment of a multi-faith roster in Hospital B.

The preferred function of religious assistance in each historical moment is also evidence of an attempted transition. Whereas in 1980 the chaplaincy model was predicated on the sacramental function of chaplains and the sacramental needs of patients, the 2009 SRAS model is predicated on the framing of religious assistance as a component part of humanization efforts in hospitals. Where chaplaincies sought to confer sacraments to their communities in hospitals, SRAS seek to provide spiritual and religious solace to patients as human beings. This is detailed in Chapter 6 of this dissertation.

Legitimacy is the single stability point in this context. While the 2009 Regulation enforces change, it does not make provisions for sustained gains in legitimacy by those religious

assistance services which complete their transition. Instead, a 2009 SRAS garners the same level of legitimacy as a 1980 chaplaincy would: both are instances of religion in a hospital. This points to one of the themes of this dissertation: while the 2001-2009 period was one of complex transformation in the Portuguese religious field, religious assistance continues to rest upon the dominant settlement of that field, where Roman Catholicism commands more resources than other religious traditions on the basis of its representativeness.

In Portuguese hospitals, these differences were reinforced from 2009. The inception of fundamental change in the religious field and State-religion relations from 2001-2004 and the 2009 experiment on the placement of religion in healthcare resulted from the need to standardize, according to broader changes in hospital organization and perceived transformations in the demand for spiritual or religious care. Based on an analysis of 1980 and 2009 legal bills, it is suggested that local orders gain importance as of 2009: hospital administrations are to designate SRAS coordinators. Representation, which was not mentioned in the 1980 bill, is determined to be relevant to post-2009 SRAS, as religious diversity and engagement with religious traditions is now mandatory. As chaplaincies, traditional functions and operations within the hospital pertained to sacramental duties linked to the traditional role of lived religion in healthcare institutions. From 2009, this was no longer the case. SRAS members were to support patients and staff in their spiritual needs and promote forms of healthy spirituality. The end result, as far as regulatory constraints were concerned, was not gains in legitimacy: chaplaincies and SRAS are not strikingly different in terms of their position in hospitals. Neither was recognized as an accredited service; neither was coordinated by an accredited physician or nurse.

The ability to react to these changes depended on existing organizational structures. This was unforeseen in the early research stage: it was expected from an analysis of the policy process that each religious assistance service would have either converged completely or remained firmly within traditional chaplaincy practice.

Table 9 shows pre- and post-2009 comparisons for Hospital A.

Table 14. Hospital A (pre-2009 and post-2009)

Hospital A	Local order importance	Representation	Function	Legitimacy
Pre-2009	Low	Low	Sacramental	Low

Post-2009	High	Low	Sacramental	Low

In Hospital A, transformations in the demand for spiritual or religious healthcare and associated regulatory change did not cause significant levels of reconfiguration. The local order, namely the primacy of cure over care and the dominant position of specialist physicians and hospital administrators who are seen by SRAS members as resistant to the maintenance of religion in the hospital, was not significant pre-2009 because, as a chaplaincy, it was mandated to report directly to the Roman Catholic Church hierarchy. After 2009, this was no longer the case. Instead, it had to engage with dominant groups and conform to regulatory changes. In terms of representation of religious diversity, the priority ascribed to increasing the number of non-Catholic representatives was never mentioned in any interview. Instead, the focus of Hospital A SRAS was on survival: for that purpose, a single strategic vector was pursued. It sought to amass community resources and structured a significant volunteering initiative which was tailored towards SRAS-parish relations. In other words, Hospital A SRAS sought to mobilize resources within its community but outside hospital boundaries. As sacramental duties are perceived to be the most important function of chaplains and religious assistance in hospitals by institutionalized religious traditions, Hospital A SRAS functions remained connected to sacramental duties, even though its head chaplain is certified in psychology and bioethics, which suggests a comprehensive skillset with the necessary level of compatibility with the challenges of SRAS models. As a legitimacy-seeking service, the Hospital SRAS post-2009 remained unsuccessful: it was not afforded significant institutional space; instead, it engaged in survival strategies outside the hospital because its legitimacy did not increase as a consequence of the 2009 Regulation on Spiritual and Religious Care.

Portuguese providers faced these problems in the pre- and post-2009 period. The chaplaincy model continues to be in use in most healthcare organizations. In hospitals, regulatory change attempted convergence, but in the cases studied for this dissertation, convergence was imperfect or remains incomplete.

The case of Hospital B strikes an important contrast to Hospital A. Table 10 shows a pre- and post-2009 comparison of Hospital B SRAS.

Table 15. Hospital B (pre-2009 and post-2009)

Hospital B	Local order importance	Representation	Function	Legitimacy
Pre-2009	Low	Low	Sacramental	Low
Post-2009	Medium	High	Humanization	Medium

Prior to 2007, religious assistance was provided in the mode of chaplaincy, but at some point between 2008 and 2009, the head chaplain engaged with incoming regulatory change and started negotiating with several religious traditions in order to develop the chaplaincy into a SRAS. Indeed, those negotiations resulted in a multi-faith roster of eligible religious tradition representatives and their full accreditation for hospital access. The head chaplain retired from intermediation by accommodating regulatory change, which required full accreditation and identification of religious representatives. This required extensive negotiations between religious representatives and the hospital administration; these negotiations were mediated by the head chaplain. The importance of the local order increased because, in the post-2009 settlement, the SRAS coordinator was to be designated by the hospital administration and the SRAS itself took steps in order to become more active in non-sacramental duties within hospital premises. The reported insistence on framing Hospital B as sacred space – and the associated role of legitimate religious representatives as gate-keepers against illegitimate proselytization – shows how a transition between chaplaincy and a SRAS model might work: in the former, the monopoly of a single religious tradition is complete enough to allow for chaplains to focus on sacramental duties; in the latter, there is no longer a monopoly and the SRAS coordinator must attend to the needs of patients and staff as a spiritual advisor of sorts. In the case of Hospital B, religious diversity and its perceived importance was the key factor in the transition. It enabled the chaplaincy to gain access to resources which it had trouble amassing through traversal within the hospital, where the cure quadrant, while not as dominant as in Hospital A, continues to exert enough dominance as to force the SRAS to seek legitimacy by enforcing regulatory requirements on the representation of religious traditions and assert its position as a fully compliant service. In becoming a compliant service, it succeeded in establishing its position and disengage from seeking survival. This is why it recognizes community-building through pastoral volunteering but does not contest existing volunteer schemes operated directly by the hospital. Instead, its priority is building up a coalition with religious traditions and generating legitimacy for SRAS nationwide. Recently, the head

chaplain was elected president of an association of chaplains and religious assistants. This is the first initiative in the country; interestingly, its statutes were approved by the Portuguese Bishops' Conference, even though it welcomes religious diversity and purports to promote increased representativeness of diversity as a pillar of religious assistance. Its core goal is to advance religion in hospitals and its highest-profile members work in public health institutions.

Finally, the case of Hospital C shows how regulatory change might produce a third configuration where baseline legitimacy and local order importance were high before the enforcement of regulatory standards. In this case, the core function of a SRAS is no longer to support or advocate for humanization; instead, it is to provide quasi-therapeutic care which derives from an inward strategic orientation. In the case of Hospital C, very little importance is given to the accommodation of religious diversity. Table 11 shows a comparison of pre- and post-2009 configurations in Hospital C.

Table 16. Hospital C (pre-2009 and post-2009)

Hospital B	Local order importance	Representation	Function	Legitimacy
Pre-2009	High	Low	Humanization	High
Post-2009	High	Low	Therapy	High

As opposed to both Hospitals A and B, local order importance was high prior to 2009. The role of the head chaplain is key in understanding the inward focus of this SRAS. Where Hospital A religious assistance was unable to traverse internal hospital boundaries to engage with physicians and, to a large extent, nurses, suggesting a very significant level of disembeddedness and therefore an outward focus, in Hospital C the statute of its religious assistance service was predicated on the skillset and legitimacy of its head chaplain. To a large extent, it was no longer a traditional chaplaincy even before 2009. This is explained by the existence of an enabling environment. In Hospital C, humanization efforts have been institutionalized to a much deeper extent than any other cases. This has been confirmed in interviews with policy officials involved in the drafting of the 2009 Regulation on Spiritual and Religious Care, as well as all religious representatives interviewed in this study. The environment at Hospital C was conducive to the embedding of religious assistance as long it surpassed the necessary hurdles towards its accreditation as a hospital support service. In 2016, with the support of an expert in

the measurement of spiritual care impact, the Hospital SRAS was in the process of completing its recognition. It is farther along the way to transform itself into a spiritual advisory service than either its Hospital A or Hospital B counterparts. As a consequence, it has devolved from community engagement and takes on a leadership role in multi-faith initiatives: it holds ecumenical celebrations at the hospital chapel but its efforts are geared towards relationships with other services in the hospital, particularly the Humanization Service, which operates under guidelines which, upon reading, suggest close cooperation between its staff and SRAS members. As a whole-organization policy, humanization at Hospital C supports the legitimization and institutionalization of religious care as it bypasses biomedical priorities and balances the primacy of the cure quadrant.

7.2 Four dimensions of religious assistance in hospitals

The chaplaincy model may operate within a local secular order, but it faces insurmountable challenges as it requires commitments by providers and their organizational co-members that none may want or be able to make. The religious assistance model becomes the only viable alternative. This is so because the local secular order, in what concerns hospitals, is empowered by the liberal democratic core of publicness and the biomedical settlement. Religious assistance is thus an adaptive reaction to the encroaching power of secular discourse. Adaptive reactions are not linear and that is the basis of the notion of religious assistance regime. In any given case, the chaplaincy model gives way to the SRAS model, but it is not clear that spiritual assistance will arise out of religious assistance. In other words, religious assistance arises from chaplaincy as a result of regulatory pressure, but further development into Spiritual and Religious Assistance Services requires conducive strategic action fields and specific skills in order to negotiate those fields. Hospital C is a case in point. Secularity and religious diversity are necessary but not sufficient conditions, because the former may come to justify the evacuation of religion from public organizations and the latter is likely to provide no basis for the emergence of spiritual assistance. Spirituality is a set of practices and beliefs that may be appropriated by religious service providers when changes in the religious field allow for questioning the continued significance of religion: simplistic debates on secularization would surmise this within strong versions of local secular orders, but this is not necessarily the case. Religious assistants may reframe themselves as spiritual assistants, but there is scant evidence that they come to represent themselves as providers of spiritual care without any religious outlook. They may, however, make sense of their position in the hospital by reframing their work as religious and spiritual. In this sense, strong secularization loses much of its appeal:

religion is simply reconfigured along less conflictive lines, thus allowing providers of religious services more space to do their work.

In contexts such as Portugal, there is no evidence that hospitals intend to provide humanistic or philosophical counseling apart from whole-organization humanization procedures, which are rare. Such assistance remains delegated to chaplains or religious assistants, which adapt to change in several ways. In this study, the strategic orientation of these changes are emphasized: providers of religious assistance may come to underline their commitment to spirituality, but only as far as it allows them to ensure survival or, where possible, gain legitimacy. An emphasis on strategic orientation does not exclude sense-making and meaning-making capacities: strategic action operates within dense cultural-cognitive environments with various institutional constraints. Chaplains in Portuguese public hospitals seek to establish and expand religious assistance because their core belief system is based on the perception that religion is valuable to human wellbeing; however, this does not exclude strategic behavior. Instead, this dissertation shows that religious assistance in Portuguese hospitals is strategic and goal-oriented. Concerns about power distribution are fundamental to actors whose identity markers are based on a belief system that is, by definition, a challenge to the dominant settlement in a public hospital. In this sense chaplains in Portuguese public hospitals seek gains in legitimacy in order to establish and expand resourceful services. This is congruent with both SAF theory and the Mintzberg taxonomy.

This dissertation is the result of a comparison between three hospitals where religious care was provided both before and after 2009. By then, regulatory change enforced convergence and it was expected that changes at service level were to be observed. But convergence is either imperfect, incomplete or inexistent. Our justification is that religious care in hospital depends more on underlying religious assistance regimes than on regulatory frameworks. Religious assistance regimes underpin religious assistance. These regimes form action profiles and drive the development of service provision. In this sense, religious assistance regimes are sets of operational ideas which confer meaning to religious assistance services and frame the position of religious assistance service members. This position is relative to other actors in the religious field, the health policy field and the hospital organizational field. This definition holds significance because it bridges the notion of regime and field: religious assistance services are instances of strategic action fields as long as there are at least discernible action patterns distributed among incumbents and challengers, as well as some discernible boundary

conditions. But religious assistance regimes may be better posited as outcomes, rather than processes, which then interact with the wider hospital organization. These are conceptual tools which arose from the comparison attempted in this dissertation. Religious assistance regimes may be split along four dimensions: organizational, strategic, institutional and cognitive.

7.3 The level of organizational integration of religious assistance

The organizational dimension of a religious assistance regime pertains to the overall organizational outlook on the position of religious assistance in the hospital. A religious assistance regime may be care-oriented and resemble traditional chaplaincies. Public hospitals are unlikely to accept chaplaincies as part of the care quadrant because skills used in religious assistance are not standardized. This is the case of Hospital A. In this ideal-typical situation, chaplains are unlikely to train in formal clinical pastoral education; instead, they are trained onsite and are largely self-taught. They do not engage with other religious traditions and religious care closely reproduces the conditions of the religious field.

The regime may be community-oriented and organized around a self-represented traditional chaplaincy service. In this case, the regime drives religious assistance to accommodate volunteering efforts, to enlarge its service in terms of religious diversity and to disengage from outright challenge to the dominant organizational settlement. This is the case of Hospital B. As an alternative, religious assistance regimes may be integration-oriented. In these cases, represented in this dissertation by Hospital C, organizational integration is preferred to community development: instead of trying to reinforce linkages to parishes or other religious traditions, the priority is to develop within hospital boundaries and frame the transition into spiritual advisory as a desirable outcome, since it would increase legitimacy within the hospital.

The organizational dimension of religious assistance regimes is fundamental because it defines the outer limits of what religious assistance services are able to do in the hospital. If they fail in stipulating appropriate representation and location in the appropriate organizational setting, given existing field conditions, chaplains and religious assistants will likely force the regime to adapt according to a strategic orientation. In the case of Hospital A, this is shown by an increasingly outward orientation: as mentioned above, the religious assistance service in the hospital ventured outside organizational boundaries in order to survive. Consequently, the institutional and cognitive components of regimes will change. What this means, in empirical terms, is that religious assistance regimes in the three cases studied for this dissertation operate

within the boundaries of the organization and the religious assistance regime. For example, the Hospital A SRAS is driven to an outward strategic orientation because its surrounding environment is not conducive to its development within boundaries. Hospital C SRAS members, on the other hand, are driven inward by the overall conduciveness of the organizational structure.

The organizational dimension pertains to the level of integration into the hospital. Table 17 suggests how integration, as reported by SRAS members, could be identified and categorized. Interaction is characterized as passive when it pertains to communication initiated by hospital staff or patients. It is engaged when either SRAS members initiate it or it is a function of appointments to other organizational decision-making bodies. Passive interaction is less relevant for SRAS characterization along its organizational dimension than engaged interaction, which illustrates the degree of integration.
In the case of Hospital A, the level of integration is low. While the hospital administration shows indifference towards religion, interaction is conflictual, as reported by SRAS members.
In the case of Hospital B, the level of integration is average. Its reported level of engagement with staff is not as low as in the case of Hospital A, but is significantly lower than in the case of Hospital C. As regards the latter, its level of integration is high.

Table 17. Level of integration into the organization

Very Low: SRAS members report low levels of interaction with staff and management and indifference towards religious assistance
Low: SRAS members report low levels of interaction with staff and management; interaction is seen as conflictual.
Average: SRAS members report average levels of passive interaction with staff and management OR low levels of engaged interaction.
High: SRAS members report high levels of passive interaction with staff and management OR average levels of engaged interaction.
Very High: SRAS members report very high levels of passive interaction with staff and management OR high/very high levels of engaged interaction.

7.4 The strategic orientation of religious assistance

The strategic dimension of a religious assistance regime pertains to the overall strategic orientation of religious assistance in a given organization. In hospitals, this is identified by the inward/outward orientation and the field position of religious assistance: where a religious assistance service is unable to traverse hospital quadrants successfully, it will likely switch strategies in order to maintain its position and survive. Regimes provide strategies because they are organizationally defined and constrained: strategies are always dependent on organizational features and orientations will be geared towards management of field position in a given, local and negotiated order. The strategic dimension captures the agentic character of religious assistance and its organizational-political development. Religious assistance services will turn to community when religious assistance is seen as having little space for action within the hospital. In other words, when religious assistance shows low levels of integration into the organization it will turn inwards, into care, when it is seen as having some space for action. The strategic dimension of religious assistance regimes is thus self-reinforcing: institutional entrepreneurship will drive more institutional entrepreneurship, while conformity and inaction will drive more conformity and inaction. But this mechanism is not deterministic, as religious assistance regimes are driven by individuals and their continued evaluation of settlements and power distribution. Furthermore, strategic orientations are driven by social skill and resources: action profiles suggested by religious assistance regimes are not only defined by their structure and interplay with other dimensions, but also by the capacity of actors to identify opportunities for strategic reorientation and their ability to employ available resources. A religious assistance service may be theoretically able to engage in coalition building, but such a course of action may be perceived as unlikely, too cost-heavy and incompatible with how religious assistance services frame their position in the hospital.

In this dissertation, strategic orientation is the most important dimension in religious assistance. It is a function of the position of religion in the hospital and determines the outlook and preferred sites of action for SRAS members. As seen in the previous chapter, this is the dimension in which the three cases studied for this dissertation differ to the highest level. In Hospital A, there is a strong identifiable outward orientation. Table 13 shows what an outward strategic orientation entails. It is based on the case of Hospital A and applies to hospitals where

the cure function is biomedical and more important than the care or community functions. This is the case of traditional chaplaincies: in these situations, there is no engagement with hospital reform in terms of humanization either because there is no humanization policy or because the costs of internal engagement are too high. Religious assistance in this case is both geared towards survival through community mobilization and thus the traversal of external hospital boundaries. Membership in hospital committees is very low or irrelevant from an operational standpoint. This is the case of Hospital A. The preferred strategic action field is that of the religious field, but allies are sought within the dominant religious tradition.

In mixed cases, religious assistance does not disengage from either organizational reform or community development. This is the case of hospital B. As the environment is neither entirely hostile nor entirely conducive to its transition from chaplaincy to SRAS, members use scarce resources to traverse internal boundaries and seek to position themselves as supporters of the care function; however, since costs are higher than in conducive organizational environments, their mixed strategic orientation drives these actors to seek allies outside the hospital. Furthermore, because their mixed strategy signals the priority of legitimacy over survival, their focus is not on reinforcing community linkages with the dominant actor in the religious field. In this case, Hospital B SRAS members have sought to create multi-faith structures on the basis of regulatory constraints, which define religious diversity as increasingly important. These strategic moves have the objective of legitimizing the SRAS in the face of internal organizational actors. This strategic orientation shows high levels of skill and a developed notion of strategic priorities. Religious diversity is used as a resource to advance the position of the Hospital B SRAS without forcing it to perform a full transition to a therapy-centered service.

The inward strategy of Hospital C SRAS shows how the strategic outlook of a transitioned religious assistance service plays out in the context of favorable conditions. In this situation, there is no outward or mixed strategic outlook. The preferred strategic action field is the organization itself. The SRAS is engaged in organizational reform and this is shown by its participation in humanization policy implementation and the operation of a Humanization Service. It is further reinforced by the process of accreditation within the hospital as a fully accredited service. The head chaplain is designated as “Spiritual and Religious Assistance Service director”. There is little to no focus on community development along the lines of Hospital A or in coalition building as in Hospital B. The organizational situation drives the SRAS to attain enough legitimacy that its main representative was able to exert influence

nationwide during the drafting process of the 2009 Regulation and in its aftermath. Instead of seeking engaged, two-way relationships, his position as the SRAS director in a very conducive environment has supported his claim to leadership, which was accepted by most individuals interviewed for the purposes of this dissertation.

Table 18. Strategic orientation of religious assistance services

Inward: Engagement in organizational reform; disengagement from community development; membership in hospital committees;
Outward: Disengagement from hospital reforms; engagement with community development; no membership in hospital committees;
Mixed: Engagement in both hospital reform and community development; mixed membership pattern in hospital committees

7.5 The institutional underpinnings of religious assistance

Organizational and strategic dimensions in religious assistance regimes are underpinned by a broader institutional dimension. The institutional dimension works with the organizational dimension in order to create structural constraints. Religious assistance is framed and contained by two different institutional dimensions: that which derives from the religious field and that which derives from the healthcare/hospital field. If the religious field is settled around a dominance pattern, it is unlikely that religious assistance services will seek to increase their religious representativeness: if religious pluralism is not seen as an important institutional driver of the religious field, it will not be seen as an important driver to religious assistance services. Legitimacy, as previously discussed, is key: if religious assistance services are not evaluated for legitimacy by their field co-members and society based on how representative they are, it is unlikely that historically inherited patterns, such as the dominance of a single religious tradition in religious assistance, will give way to other patterns of organization.

The choice over these courses of action is dependent on strategic orientations and the organizational possibilities afforded to religious assistance. An analogous process operates regarding biomedicine. Religious assistance regimes grapple continuously with secular formations and their course of action dictates their stance: these regimes may be openly hostile

to existing settlements and argue for a more expansive notion of publicness and medical care, or they may be accommodative and seek to defuse conflict by asserting their allegiance to the secular settlement in publicness and biomedicine.

The institutional dimension seems, so far, the least sensitive to translation into local, negotiated orders. But it is the most sensitive dimension, as it demands interpretation by all existing actors operating under a local order. These actors operate under daily constraints and need to assess their situations according to institutional frames of reference. Religious assistance regimes are no different: while a single regime may exist under the aegis of law, each organization where religious assistance services operate will present its own set of institutional features. In other words, each public hospital will present a specific, but not unique, configuration of publicness and biomedicine.

Table 14 shows representativeness/pluralism as one of two institutional components of religious assistance. In hospital A, representativeness is the single focus. Driven by the organizational dimension and the strategic outlook, it does not attempt to engage with religious diversity as a core regulatory demand nor with religious diversity as essential to

Table 19. Institutional underpinnings of religious assistance

Representativeness: Importance of demographic significance in the structure of religious assistance underpinned by the reproduction of the dominant settlement in the religious field
Pluralism: Importance of demographic significance in the structure of religious assistance mitigated by the accommodation of religious diversity as a resource
Community: Importance of maintaining close linkages to traditional communities (parishes or institutionalized religious structures) to the detriment of investment in internal hospital relationships
Care: Importance of maintaining close linkages to medical communities (physicians/nurses/administrators) to the detriment of external hospital relationships (other religious traditions or parishes/institutionalized religious structures)

religious assistance in hospitals. As it is focused on survival, its focus centers on the representativeness of its work: both in terms of demographic significance, as it purports to represent most patients in the hospital, and in terms of its existential significance, as it suggests that most patients in the hospital, as most members of society, require religious care in the hospital. As such, it has very little to gain from investing in religious pluralism; engaging in coalition building, as was the case of Hospital B, would be too costly and threatening.

In Hospital B, the situation stands in sharp contrast. Instead of playing up on its representativeness, it has sought religious diversity as a means to make gains on its position within the hospital. Because regulatory constraints demanded improvements in the conditions offered to all registered and accredited religious traditions, SRAS members have engaged in dialogue with locally represented religious traditions and are now the only service in the Portuguese hospital network with a multi-faith roster. Furthermore, this is the only hospital where fully independent accredited religious representatives were able to enter premises without the intervention of employed SRAS members.

In Hospital C, the situation should be difficult to ascertain, given that we established that it now resembles a fully accredited support service in the hospital and no longer fits description as traditional chaplaincy or transitional chaplaincy. However, transition has not transformed the institutional dominance of representativeness. In this sense, it more closely resembles Hospital A than Hospital B. It has not arranged a multi-faith roster and, where multi-faith initiatives have been sponsored, Hospital C has always maintained a position of dominance. In this way, the dominant settlement in the religious field was not brought into question by the transition from chaplaincy to SRAS. Religious diversity is not a priority. Instead, its commitment to SRAS as a hospital service instead of a religious care service was underlined in our fieldwork and in discussions with interviewees. This does not entail, however, a knowing abandonment of religious belief by the service. Hospital C SRAS members are regularly called upon to discuss Christian theology at various venues; but their main focus is no longer on sacraments. It is on bioethics, humanization and the questioning of biomedicine as a byword for secular dominance. Paradoxically, the emphasis on transformation from chaplaincy to a full SRAS model has been a response to the perceived threat of secularity and cure-focused practitioners who do not value holistic practice. In institutional terms, the care orientation of this service does not use insights from religion in order to support its claim to legitimacy in the hospital. It is no longer concerned with survival. Instead, it defines its mission in terms of

advancing therapy-centered practice with the goal of questioning the illness focus of modern medicine. In the process, it has become a fully accredited service.

7.6 The cognitive orientation of religious assistance

The cognitive dimension of religious assistance regimes pertains to the reference frames used in the definition of what religious assistance is and its boundaries in an organization. This dimension operates in close interaction with the strategic dimension: cognitive parameters are causal components of strategic orientations.

Religious assistance regimes which emphasize the religious dimension of religious assistance will show a strategic orientation towards the religious field. Religious assistance regimes which emphasize the assistance dimension of religious assistance will show a strategic orientation towards the healthcare field. This could be reinforced by the organizational and institutional dimensions. Empirical analysis shows that two frames operate in this dimension: a professional frame and a chaplaincy/sacramental frame. The professional frame drives religious assistance services to equate their action profiles with care professionals: religious assistants are likely to engage patients as spiritual assistants and providers of humanization in a dehumanized setting. In this instance, skills are likely to become standardized: religious assistance is bound to become part of the professional bureaucracy if religious assistants see themselves as health professionals and take steps, both within the organization and without, to standardize their skillsets. The sacramental frame operates in the opposite direction. Table 15 shows four sets of ideas which underpin the configuration of service provision.

Table 20. Cognitive orientation of religious assistance

Therapy: SRAS seen as therapeutic and focused on individual care relationships; Human being represented as whole person; emphasis on holistic care and religious assistance as essential
Humanization: SRAS seen as humanizing and focused on organizational change; Human being represented as social being; emphasis on service provision and quality

Spirituality: SRAS seen as attending to meaning-making and focused on individual care relationships; Human being represented as spiritual but not necessarily religious; emphasis on personal meaning and understanding
Sacramental: SRAS seen as pastoral care and focused on communal liturgies; Human beings represented as essentially religious; emphasis on ritual and devotion.

Religious assistance services are likely to remain closely identified with the chaplaincy model: religious assistants are, first and foremost, adept at touching upon issues of lived religion and theology, refraining from using neutral vocabulary. Instead, they choose to remain firmly within the religious field and cast themselves as outsiders to the organization. Their ability to traverse quadrant boundaries in the hospital is limited, but their capacity to seek support in society may be augmented.

These two ways of negotiating the cognitive dimension of religious assistance is captured by the use of spirituality and holistic conceptions of human experience. The professional frame will likely nudge religious assistance services to strategically orient themselves towards catering to the spiritual lives of patients, independently of their religious affiliation. This is a response to strong secularities in organizational environments and the embeddedness of secularity in the publicness and biomedical institutions. The interesting point here is that the cognitive dimension is also likely to drive religious assistance services to conceive their action and field position in agentic terms. Cognitive definitions, in this sense, are never given to actors who are then bound to act without volition. Instead, the cognitive dimension is both cause and consequence of all other dimensions in religious assistance regimes. If a given religious assistance service defines its work as a form of professional care, it is likely that it will strategically act towards organization-wide recognition and institutional change; if it defines its work as a form of sacramental care, it is also likely to act strategically towards those ends. What changes is the substance of claims and the compatibility of those claims with field settlements. If religious assistance services are cognitively oriented towards seeing their work as spiritual care, they are likely, because public hospitals operate under core normative assumptions that validate spirituality and invalidate traditional lived religion, to be more easily integrated into hospitals.

In the case of Hospital A, the cognitive orientation remains towards a sacramental understanding of religious assistance in hospitals. This stands in contrast to the personal views of its head chaplain, who does not see sacramental work as fundamental to religious assistance in hospitals. Instead, interviews have shown that the Hospital A SRAS head chaplain voices an acute preference for the path taken by the Hospital C SRAS: instead of pursuing sacramental work, there is a stated preference for spirituality, humanization and eventually therapy. However, organizational constraints do not allow for the pursuit of these orientations. The Hospital A case is that of a reluctant chaplaincy: it strives for survival and, because the environment is not conducive to engaging in change, the approach is conservative and predicated on survival. For these reasons, it does not traverse internal boundaries, preferring in its place to engage the Roman Catholic community outside organizational constraints and build resilience from pastoral volunteers.

Hospital B is not necessarily conducive to the embedding of religious assistance, but it shares little similarity to Hospital A. The hospital SRAS and its members are not concerned over survival and do not show an outward strategic orientation. The focus in this case is a mixed strategy which utilizes religious diversity as a resource in order to legitimize itself and make inroads into the hospital. This is why the head chaplain reports strong reactions by the medical community to the SRAS' ability to engage with religious traditions outside organizational boundaries and mediate their entry into premises while institutionalizing their rights as written into law. Coalition-building in this case is fundamentally a function of legitimacy-seeking. Interestingly, this strategic orientation has led to the pursuit of humanization and allegiance with psychiatrists, first and foremost, within Hospital C. SRAS members in this case reported, in interviews, concerns over staff mental health without being primed or asked about the topic. This is also the case where a more articulated understanding of the policy process was presented, to the extent that the SRAS was able to largely preempt its consequences. The focus on humanization is largely based on the orientation provided by its head chaplain, who explicitly seeks to traverse hospital boundaries and engage with psychiatrists and nursing staff, so as to advocate for the role of religion. In a specific sense, this SRAS is the most invested in the cognitive orientation towards spirituality, albeit incipiently. Instead of insisting on sacramental duties, there is significant focus on spiritual care and spiritual health.

In Hospital C, the advanced transitional stage from chaplaincy to a full SRAS model is shown in its investment on the therapeutical legitimacy of religious assistance. Its organizational

environment is conducive to such investments and this is part of the explanation of its strategic orientation. However, it is also evidence of how much further into its transformation this case is compared to the two others studied in this dissertation. Given that Hospital C is invested in humanization as a whole-organization policy, its SRAS is now geared towards a further step into legitimacy and full embeddedness in the care quadrant. As mentioned before, it is in the process of accreditation as a hospital service. The process requires a demonstration of performance impact and therefore the quantification of religious assistance care capacity in terms of patient well-being. This is why ambivalence towards quantification of spiritual well-being was shown at a training course for chaplains and religious assistants. While the Hospital A head chaplain looks upon these developments with an approving gaze, the Hospital B counterpart is much more reluctant. This is explained by each SRAS' level of organizational integration, strategic orientation and institutional underpinning: where the Hospital A SRAS attempts to negotiate through a difficult local order and ensure survival through community-building, the Hospital B SRAS has successfully negotiated its local order by preempting regulatory change and using religious diversity as a legitimacy-augmenting resource. In one case, there is an advantage in the Hospital C SRAS example: it shows how legitimacy may be gained and consolidated. In the other, the pursuit of conversion into a hospital support service is seen with some reluctance because the strategy pursued was successful. In this sense, Hospital B SRAS shows higher levels of skill and a more acute perception of how the religious field and the health policy field impact each other. Reluctance to pursue a full transition into an accredited and performance-oriented service does not originate in any specific sense of belonging to a traditional chaplaincy model; it is a function of adaptation to a specific local order and a specific mode of living religion in the hospital.

7.7 A comparative synthesis of religious assistance in three Portuguese public hospitals

As a consequence of the proposals shown above, we may summarize findings. Table 16 shows a summary of findings.

Table 21. Comparative summary of Hospital A, B and C

	Organizational integration	Strategic orientation	Institutional underpinnings	Cognitive orientation

Hospital A	Low	Outward	Representativeness/ Community	Sacramental
Hospital B	Average	Outward	Plurality /Care	Humanization/ Spirituality
Hospital C	High	Inward	Representativeness/ Care	Therapy/ Humanization

Hospital A illustrates a case where religious assistance is not beyond a traditional chaplaincy model. Its level of organizational integration is low. As proposed in this dissertation, this leads to a strategic orientation towards exiting the hospital strategic field and to emphasize its linkages to its traditional faith community (in this case, the Roman Catholic community) through the mobilization of volunteers. Thus, its core institutional underpinning is that of representativeness, because emphasizing religious field plurality would be detrimental to its efforts in community-building; it insists on its rights and those of patients which are represented as mostly Roman Catholic. Its cognitive orientation is sacramental, as a consequence of its strategic orientation towards reinforcement of linkages with communities outside the hospital. Hospital B illustrates a case where religious assistance is beyond a traditional chaplaincy model, but not necessarily in transition to a full SRAS model. Instead, its average level of integration into the hospital has been skillfully used by its members, namely the head chaplain, as a means of gaining legitimacy. The main vector in this operation was religious diversity in the aftermath of regulatory change. Instead of resorting to traditional linkages, the SRAS at Hospital B has sought to build coalitions with religious traditions and bring them into the hospital. This is why it operates a multi-faith roster of a growing number of religious representatives and has actively pursued its exclusion from the mediation of entry by accredited religious representatives into the hospital. Paradoxically, it is also because it does not emphasize representativeness that, more than in the other cases, the role of SRAS members as keepers of the sacred space of hospitals and sacred right of patients to remain undisturbed is emphasized. Proselytization by illegitimate religious traditions was emphasized in interviews as one of the main concerns of SRAS members at Hospital C and its prevention was described as one of the core duties of SRAS members at any hospital. These duties were framed in terms of spiritual well-being instead of sacramental rights over the faithful: faith healing and other practices deemed as illegitimate by a majority of religious representatives interviewed for this dissertation are seen not as detrimental to religion in the public sphere but as detrimental to

actual health and well-being levels of patients within hospitals. These were framed as spiritual and humanistic concerns. The cognitive orientation is a hybrid: it melds humanistic concerns with a spiritual framework where religion in hospitals is perceived as plural and not necessarily tradition-oriented. In this case, an average level of organizational integration has been used by skillful individuals in order to produce an unforeseen solution which highlights the connection between apparently distant strategic action fields, such as the religious and the health policy field.

The case of Hospital C stands in relatively sharp contrast to Hospital A. It is strategically oriented inward. In other words, it favors action within the hospital, as the costs of traversing internal boundaries and engage with physicians and nurses are very low. This is a function of individual skill, but also of organizational conduciveness: as mentioned before, Hospital C operates a unique Humanization Service and supports a whole-organization Humanization Charter. These were built with the support of the local SRAS. Furthermore, an important topic of discussion is the ongoing plans for a multi-faith prayer space within hospital premises. This would signal both an outward strategic orientation and a plurality institutional underpinning. However, tracing the policy process of the 2009 Regulation on Spiritual and Religious Care shows how those plans are motivated by a continued reliance on the institution of representativeness, which ascribes leadership to a single religious tradition on the basis of its demographic significance. Instead, what those plans show is how the level of integration of the Hospital C SRAS produced a different solution as compared to the other cases studied for this dissertation. In coming to terms with regulatory change, the Hospital C SRAS did not commit resources to its survival and did not have to engage in creative action in order to take advantage of a critical juncture. Instead, it exerted influence at a broader level in order to change regulatory standards and enforce representativeness as a general institutional underpinning. During the policy process of the 2009 Regulation, as documented above, interviewees for this dissertation report that the Hospital C chaplain was the key actor in contesting the initial draft of the bill, which was seen to be severely against religion and religious assistance in hospitals. As reported above, religious representatives sought to take advantage of threats on the dominant settlement in the religious field and were chastised by the Hospital C SRAS head chaplain on the basis of representativeness and not plurality. These events show that the commitment to plurality is very weak in this case. Instead, the Hospital C SRAS is committed to its cognitive orientation towards therapy and humanization. During interviews, few individuals mention spirituality as a focus in this hospital. Instead, there is a sharp focus on therapy. We propose that focusing on therapy-oriented practice signals a transition from

chaplaincy – even if unconventional – to a full SRAS, where practitioners are no longer just designated by their religious traditions but are required to complete formal training and must show measurable performance impact in terms of hospital outputs. In other words, transitioning into a full SRAS is not a completed process, but it is suggested that measurable religious assistance is an initial stage towards spiritual advisory where the actions of individuals who take up the role of chaplains are measured in terms of their impact and cost-benefit ratio.

7.8 Provisional answers to research questions

In the introduction to this dissertation, we formulated three research questions:

1. Why do public healthcare institutions facing similar regulatory constraints show different patterns of religious assistance?
2. How do religious representatives act upon perceived constraints in terms of their lived religious experiences?
3. How does instability transfer from one strategic field to another (in this case, from the religious field to the healthcare policy field)?

From 2001 to 2009, Portuguese public healthcare institutions faced similar regulatory constraints in terms of religious assistance provision. During this period, several changes occurred which impacted the religious field and the health policy field. Among these changes, regulatory changes to the provision of religious assistance in hospitals were among the most relevant, particularly when we consider the religious and the health policy fields as they relate to one another. If we sharpen our focus to the role and position of religion outside its traditional settings, namely institutionalized religious venues or instances of inter-religious dialogue, hospitals become an interesting site for observation. It would be expected, given the centralized character of healthcare provision in Portugal, that regulatory changes would impact similarly-categorized organizations and produce similar or strongly convergent patterns. During the course of this dissertation, it was proposed that, contrary to expectations established prior to the start of research and suggested by the general scope of regulatory enforcement, patterns of religious assistance did not become more similar in three structurally similar organizations. Hospital A, B and C are placed at the apex of the Portuguese Healthcare System. All three hospitals are larger than their counterparts. But patterns of religious assistance did not become standardized and do not show any significant indication of convergence. Instead, patterns of religious assistance were shown to depend on the existence of organizational environments

conducive to the establishment or maintenance of religion in hospitals. Chaplaincies initiate processes of transition into Spiritual and Religious Assistance Services if environment are conducive enough to allow SRAS representatives to modify their cognitive orientation from sacramental priorities to humanization, spirituality or therapy priorities. These patterns are predicated on the existence of specific dimensions of religious care and the capability of individuals to negotiate local orders. We propose a fourfold set of dimensions: the level of integration into the organization, the strategic orientation of religious assistance, the institutional underpinnings of claims to legitimacy and the cognitive orientation of religious assistance members. The three cases studied in this dissertation show differences in these dimensions, but all three have reacted, in some way, to regulatory change.

The interplay between dimensions in each of the three cases is the most important finding of this dissertation. In Hospital A, the organizational context is hostile to religion and religious assistance. The SRAS in this hospital shows low levels of organizational integration. This increases the costs of remaining within hospital organizational boundaries and of internal boundary traversal. The SRAS at Hospital A shows the highest difficulty level in engaging physicians and hospital administration. This determines an outward strategic orientation in order to ensure survival. The SRAS is dependent on reinforcing linkages to its traditional target communities and does not engage with the wider religious field to any significant extent. Thus, its institutional underpinning, representativeness, actually reinforces the strategic orientation and drives the cognitive orientation towards sacramental care. This is because, in electing community-building as a survival strategy, the SRAS at Hospital A caters to the needs of its target community and does not engage openly in a transition towards humanization or therapy-centered religious assistance.

In Hospital B, the organizational context is not hostile towards religion but is not definable as conducive to the establishment of religion or religious assistance outside regulatory requirements. The level of integration into the hospital is average. Interestingly, this has allowed for a wider scope for action by SRAS members in negotiating change. Because its organizational environment was not hostile and did not threaten its survival, the strategic orientation of the Hospital B SRAS was mixed. The institutional underpinning in this case is not representativeness, because SRAS members did not identify the need to seek traditional community resources in order to survive. Since the priority was centered in gaining legitimacy and the head chaplain at the service held sufficient skills to engage with regulatory standards from a vantage point, religious diversity was used as a resource to gain legitimacy while ensuring commitment to regulatory change. For this reason, its institutional underpinning is

plurality: the core differentiating pattern in the case of Hospital B SRAS is coalition building within the religious field and a compromise with existing volunteer efforts at the hospital; instead of seeking alternative community-building pathways, it recognizes that SRAS volunteers are engaged in belief-specific action and advocates for pastoral training, but does not discount secular volunteering or attempt strong institutionalization of volunteering efforts, as is the case in Hospital A. As a consequence of its average level of integration, it does not show any marked orientation towards sacramental duties. Instead, it is oriented towards humanization of a specific sort: in protecting what SRAS members perceive to be sacred space (the hospital) and sacred bodies (those of patients) from proselytization, the Hospital B SRAS sees itself as protecting the spiritual well-being of patients.

The Hospital C SRAS shows a different pattern, but its dimensions show a significant level of logical congruence in terms of their mechanics. Where the Hospital A SRAS shows a very low level of integration into the organization, its Hospital C counterpart shows a high comparative level. This has paradoxically reduced the scope of potential action: its trajectory shows a higher level of path-dependence than the other cases because its level of integration ensured a legitimacy baseline which determined other dimensions of religious assistance. In this case, the organizational context is conducive to the establishment and legitimization of religion; resources available to the SRAS in this hospital were comparatively more abundant than in any other case, as the skillset of the local head chaplain entailed the practice of lobbying against the initial draft of the 2009 Regulation on Spiritual and Religious Assistance. As determined in interviews for this dissertation, the role and influence of the head chaplain is not discernible without engaging with the Hospital C SRAS itself. It was only because the Hospital C SRAS enabled the positioning of a single individual into an influential role that that same individual was able to commit resources to political entrepreneurship. This enabling capacity is a function of the inward strategic orientation of this SRAS. As mentioned before, the focus on care and the institutional underpinning of representativeness are consequences of integration and conduciveness; in this context, the cognitive orientation towards therapy is both a predictable consequence of humanization and an unpredictable consequence of the inward strategic focus. Since the goal of any of the religious assistance services in this dissertation is survival and legitimization, transformation into a SRAS from the traditional chaplaincy model is a consequence of emphasis on relationships with medical staff. The costs of traversing internal organizational boundaries, for the Hospital C SRAS members, is at least as low as traversing external boundaries.

The policy process of the 2009 Regulation was a critical juncture during which the dominant settlement in the religious field was questioned as a result of instability in the healthcare policy field. In this sense, instability in one field translated into another, distant field. There was no comparable controversy on the exceptional position afforded to the incumbent actor in the religious settlement – in the case of Portugal, the Roman Catholic Church – in the 2009 Regulations on Spiritual and Religious Assistance in Prisons or the Military. Instead, because the structure of the healthcare policy field is defined by the prominence of religious providers, which continues to be evinced by the presence of paid religious assistance (and its regulation) in public hospitals, instability and contestation over the dominant settlement in the religious field quickly transferred into the healthcare policy field. As mentioned in Chapter 5 of this dissertation, evidence that the 2009 Regulation on Spiritual and Religious Care in Hospitals caused turmoil within the incumbent Cabinet and forced the then-Prime Minister to assure the Roman Catholic hierarchy that there would be no significant change to the existing settlement in the religious field, as far as the Portuguese State was concerned, shows that these fields are connected by religious assistance in hospitals.

7.9 Conclusion

This dissertation is an investigation into the policy process of religious assistance in Portuguese hospitals. It is also an investigation into the impact of regulatory change on actually existing religious assistance services in three large-scale, high-end public hospitals in Portugal. As a field-theoretical study, it takes the strategic orientations of actors as the most important determinants of patterned action. As a research process, it attempted to discern the impact of policy on actually existing organizations and actually existing practitioners. The role of strategic fields was emphasized in order to ascertain their theoretical potential: we proposed that State-religion relations institutional arrangements are nested fields where multiple actors operate under shared assumptions, namely settlements over rules of engagement and hierarchies. The Portuguese hospital case suggests that instability does not necessarily translate either into reinforcement or complete replacement of dominant settlements. Religious assistance becomes a research question as it lies at the fringes of both the religious field and the healthcare policy field. Chaplains, in the case of Portuguese hospitals, operate at the margins of both their institutionalized religious organizations and their places of employment. During the research process, this dual marginal situation suggested that religious assistance, particularly in high-end public hospitals, was an interesting research topic because it allowed

for an analysis of two different strategic action fields and for a reflection on the role of religion in public institutions.

From 2001 to 2009, State-religion relations in Portugal changed to a larger extent than in any other period since 1975. The Portuguese State enacted regulatory change which reemphasized its role as a key actor – in field-theoretical terms, as the internal governance unit – in the religious field. Regulatory changes impacted religious assistance to a significant extent, but not in a direct, linear fashion. Instead, regulatory change was mediated by local orders and specific individual skillsets. These interactions produced different patterns of religious assistance in each of the three cases studied for this dissertation. These patterns are as follows:

In Hospital A, a traditional chaplaincy model remains. In Hospital B, a plural humanistic model has been put into place. In Hospital C, a therapy-oriented model has replaced chaplaincy. Convergence, where identifiable, is either incomplete (as in Hospital B) or imperfect (as in Hospital C). Regulatory change, particularly in its focus on the potential of religious diversity, opened a critical juncture which allowed for contingent differentiation according to organizational constraints and exigencies.

As a comparative case study, this study does not assert any generalizable inferences. Its case selection is limited and its focus on a very specific component of organizational structures and processes limits our ability to provide complete generalizations. However precise the case selection procedure may be, small-N studies are rarely able to produce orthodox results in terms of what is currently held to be desirable as social science. This is the case of this dissertation. The three cases used in this comparison, which have been selected upon consideration of the complete Portuguese hospital sector, show structural similarities which make them appealing candidates for comparison. However, an indeterminate number of variable may not have been considered: either because current literature does not point to them as relevant factors or because emergent complexity prevents their inclusion in a comparative case study, under the risk of making the study itself unwieldy. Apart from the trivial and proven insights that negotiated local orders matter, it would be imprudent to suggest generalizable inferences. Instead, we have sought to construct theoretical building blocks and develop theory on the basis of empirical research. This emerged during the course of research as the most appropriate goal for a study of this kind. It remains to be seen whether the goal was attained. For this purpose, religious assistance and the question of religion in public institutions was an especially challenging research problem. The literature remains in development at the time of writing: it has not yet reached a stage of maturity which one may identify within the wider field of social studies of religion, public policy of even State-religion relations. This is why this dissertation

seeks to introduce strategic actions fields as core theoretical concepts: because religious assistance in hospitals is under-theorized while providing insights to larger questions in social research, it was found that engaging in theoretical discussions and risking theory development was both appropriate and worthy of inherent risks.

In its attempt to provide building blocks on which to develop more sociological knowledge on the dynamics of displaced religion in Portugal and, by extension, Western Europe, this dissertation has discussed the implications of policy processes which are entangled in multiple strategic action fields. It was only during the research process that controversies over the role of the State in the governance of religion and the continued primacy of religious traditions in the Portuguese religious field were identified. Traditionally, the post-1976 Portuguese State is defined as non-confessional; its policy priorities are driven by a self-professed "principled distance", as an interviewee for this dissertation asserted[65]. During the research process, these tenets came into question. Religious assistance in hospitals is not generally seen as a politically sensitive topic. However, this dissertation shows that, where contestation over dominant settlements exists, political controversy will follow. This is what occurred both before and after the 2009 Regulation on Spiritual and Religious Care in Hospitals. The dominant settlement, which ascribes dominance to a single religious tradition, was questioned. It is not clear that its questioning resulted in any kind of disenfranchisement. Instead, resettlement and reinforcement, as the central argument of this dissertation proposes, has been the observable conclusion.

The theoretical issues presented over this dissertation show that the *loci* of research as regards State-religion relations and religious assistance in public institutions may be extended and, in the process, enrich available interpretive tools. The research problem of organizational secularity is envisioned as the next step of the process started in this dissertation. One of our findings is that State-religion relations are arrangements which exert some influence over local orders, but the consequences of that exertion are not identifiable in any linear way. Hospitals, for example, contextualize religion through framing devices which are bound to medicine and the preferences of medical personnel. In each hospital, secularity manifests itself not only in the position and legitimacy of religion but also in its absence. In other public institutions, these forms of organizational framing of religion, which are plausibly defined as organizational secularity, could be profitably compared within and across categories, sectors and geographies. This is the next step in the research process started in this dissertation. The secular is not given

[65] Interview, former Health Minister.

by a larger institutional arrangement; indeed, one would be hard-struck to identify a context-independent secular order across organizations. Instead, what field research shows is that secularity is not only sector-specific, but also organization-specific: secular orders vary across hospitals within the same property scheme (public-private) and it is expected that variation of this type occurs in other sectors, namely the school and prison sectors. Schools operating at the same level may well show different levels of patterned variation on organizational condensations of secularity, instead of being akin to each other. As Charles Tilly would suggest, it depends. As a next step in research, studying variations across these possibilities (within sector, across sector; within property scheme, across property scheme) and across national, regional and local contexts would further enrich the literature. As regards geographic scales, it would provide further insight into whether traditional State-religion relations exert an impact close to that advanced in the literature surveyed above, and, that being the case, what are the mechanics of impact exertion. In other words, if it is found that State-religion relations is an important institutional arrangement in the consideration of religious assistance, how does it actually impact the provision and operation of religious assistance? Is impact exerted as legal constraints enter into force? Is it a mix between legal constraints and cognitive restructuring?

Alternatively, State-religion relations may not be as important as suggested: instead, organizational secularities may be the drivers of the organizational positioning of religion, which would then also suggest that actors-in-fields are more important than large-scale configurations. This is the conclusion of this study. Hospitals operate within constraints, certainly, but the reflective action taken by actors within hospitals suggests that State-religion relations, as an institutional arrangement, is less important than other problems facing actors in the organizational field. In this study, we sought to identify the secular within medical paradigms operating as the symbolic machinery of a hospital: the biomedical gaze imposed on patients and chaplains is inherently secular and thus imposes relevant demands on those subjects who seek to bring religion into the fold. These are questions which could be pursued on the basis of this study.

As regards religion in hospitals, and particularly the roles and perceptions of religious representatives, the interplay between medical and religious discursive codes, and the cross-pollination between theology, bioethics and biomedicine, would further theoretical capacity brought by researchers into fieldwork. One of the most troubling issues during the course of this study was the relatively impoverished theoretical toolbox, not only empirically but philosophically and theologically, made available to early-stage researchers.

As a final concluding remarks, the bounded character of this study shows the limits of current continentally-confined research. As a three-case study confined to a single national context, it would seem to be the case that limiting research to a number of geographically close contexts would be most appropriate. This has been the underlying, perhaps tacit logic in research on religion. However, a further, probably important avenue of research is the pairing of odd couples along more challenging scope conditions. For instance, the pairing of Portugal, Spain and any given Latin American country remains largely unknown in the sociology of religion or religion in public institutions. Further, a close reading of the literature on families of nations and clusters would suggest that intercontinental pairing are likely to produce more interesting results in the medium-term, particularly if researchers pay closer attention to links between cases resulting from imperial histories and domination. While research on citizenship is fully aware of these possibilities, religion in public institutions is now starting its engagement with these questions.

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